Exploring the Factors of Suicidality in Individuals with Level One Autism Spectrum Disorder

Dissertation Manuscript

Submitted to National University

in Partial Fulfillment of the

Requirements for the Degree of

DOCTOR OF PHILOSOPHY

by

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San Diego, California

April 2026

Abstract

There is a lack of information about individuals with autism who are regularly experiencing suicidality. The problem addressed by this qualitative phenomenological study was to learn about the lived experience of individuals with level one autism who have experienced suicidality. The purpose of this study was to learn about the factors that led to the high prevalence of suicidality, lived experiences of suicidality, and the factors of suicidality that are experienced by individuals with autism. Data was collected through recorded phone calls during semi-structured interviews that were linked to the problem, purpose, and research questions. A total of seven clients' experiences were shared by their therapists from the states of Washington, Wisconsin, California and Oregon.

The *Interpersonal Theory of Suicide* states that individuals process through at least three stages to suicide: thwarted belongingness, perceived burdensomeness, and acquired capability (Joiner, 2005). Mental health professionals and researchers are impacted by the individualized information gathered, and how the clients with autism in this study did not process through the suicidality theory as expected. Future research is needed in this area.

Mandated reporters are impacted by this study due to the childhood trauma and abuse. These experiences led to suicidality for every client and effected adult relationships significantly. Mental health and healthcare professionals are impacted by these results, and can learn what is needed when an individual with autism is experiencing suicidality. Creating access to suicide programs, individualizing questionnaires and intake forms at clinics and emergency rooms to include communication, poverty, abuse, and immigration issues will help with suicide prevention, especially for individuals with autism.

Acknowledgements

I would like to thank all my family and friends for encouraging me, being a listening ear, and keeping me together when I was off track. I would like to specifically recognize: All my parents though they are no longer physically with us, for inspiring my love of learning, instilling perseverance, and showing me how to always have love, faith and hope.I miss all of you. To Karen Sumner for always checking on me. It is important and always appreciated. To Nicholas Dean and Ryan Michael, I am forever grateful for your continued love, support, smiles and input. To Kristen Musselman, you have always been the friend I never knew I needed. Thank you for always being there for me for all things. I hope you know how much the words of support and encouragement mean to me. And last, but not least, Joseph Girillo, my oldest and dearest friend who often knows me better than I know myself. Thank you all from deep down in my heart for being with me on this journey.

I would like to thank Northcentral University and its staff for their support and guidance throughout my program. I would like to specifically thank Dr. Natalie Costa, my Dissertation Chair, for her guidance. I would also like to thank Dr. Trepinski, Subject Matter Expert, and Dr. McNamara, Academic Reader, for providing helpful and detailed feedback that was instrumental in helping me produce a well-written dissertation. Their impact on my journey to a Ph.D. has been enormous, and I am truly grateful for their contributions and support.

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Chapter 1: Introduction

Autism spectrum disorder (ASD) is a lifelong neurodevelopmental disorder depicted by challenges with reciprocal social communication, sensory sensitivities, developing and maintaining relationships, and repetitive and / or restricted behaviors and interests, according to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association [APA], 2022). Individuals with level one autism spectrum disorder require the least amount of support of the three severity levels provided by the DSM-5-TR (APA, 2022). Restricted, repetitive patterns of behavior and social communication issues represent the three severity levels: Level 3 – requires very substantial support; Level 2 – requires substantial support; and Level 1 – requires support (DSM-5-TR; APA, 2022). An individual with Level 1 social communication issues may be able to engage in a conversation, but the reciprocity of an extended conversation would be unsuccessful. Similarly, restricted behaviors may be apparent for an individual with level one autism, and cause a disruption when there is an abrupt change in schedule or activity. This study used participants who were diagnosed with Level 1 autism spectrum disorder (DSM-5-TR; APA, 2022). Individuals with autism have a high risk of suicidality compared to their non-autistic peers (Cassidy et al., 2014; Newell et al., 2023).

Individuals with ASD have often had experiences of suicidality that differ from their non-autistic peers (Dow et al., 2021; Jachyra et al., 2022). Suicidality research in autism has increased over the last decade. Early research studies show a wide-range prevalence from 1-72% for suicidal ideation from a review by Hedley & Uljarević (2018), and 1-47% range for suicide attempts for individuals with autism. The wide ranges may have occurred due to differences between research variability (e.g., sample size, suicide assessments) and/or differences between

autistic and non-autistic traits (Newell et al., 2023). A large population study in Sweden also showed that adults with autism were more likely to die from suicide and self-harm than the general public (Hirvikoski et al., 2016; Kirby et al., 2019).

Recently it has been found that middle-age and older adults with autistic traits were found to have a 5–fold increase risk for suicidality (Stewart et al., 2023). Males, age 65 and older are at the highest risk for suicide in the U. S. due to serious illness, loneliness, and/or bereavement (DeLeo, 2022). Psychiatric diagnoses, according to Lai et al. (2023), are related to suicide in both females and males with autism. It is clear that individuals with autism experienced a higher level of risk toward suicidality than those without autism (Newell et al., 2023).

In the U.S. in 2021 suicide was ranked the 11th highest cause of death, which equals a total of 48,183 deaths by suicide. Currently the provisional data for 2022 shows suicide has increased by 3% overall (totaling 49,449 people) with females increasing by 4% and males by 1% from 2021 statistics (Curtin et al., 2023; National Center for Health Statistics, 2023). Just as the numbers are increasing for suicide, the numbers for individuals with autism are as well. The current prevalence is approximately 1 in 36 children (or approximately 2.8%) under the age of 8 years diagnosed with ASD, according to the Center for Disease Control and Prevention (CDC; 2023). In a new process for the CDC (2023), the estimated prevalence for adults with autism in the U.S. is 2.21% using 2017 data (Dietz et al., 2020). There are significant gender differences with four times as many males as females diagnosed, in addition to 39% of females diagnosed with an intellectual disability co-occurring with ASD compared to 32% of males (CDC, 2023). Females are often undiagnosed or misdiagnosed, and therefore more at risk for suicidality due to camouflaging (masking) and diverse presentation of repetitive behaviors (APA, 2022; Suckle, 2020). Statistical data helps the government and researchers find and understand areas of need.

There are risk factors that can increase the possibility of suicide for individuals with autism and those without autism. The CDC (2023) categorizes risk factors that may add to the possibility of suicide into four categories: individual, relationship, community, and societal. Mental illness, previous suicide attempts, serious physical illness or pain, self-harm, and substance abuse are common individual risk factors that can lead to suicidality for people with autism more often than those without autism (Cassidy et al., 2018; Dow et al., 2021; Jachyra et al., 2022; Moseley et al., 2020a). Relationship risk factors include family history of suicide, camouflaging, relationship issues (e.g., break-up, loss, violence) and social isolation (Cassidy et al., 2020; Hirvikoski et al., 2020; Joiner, 2005; Trundle et al., 2022). Community risk factors include discrimination and lack of access to medical and psychiatric healthcare (Cassidy et al., 2022; CDC, 2023). Societal risk factors include access to weapons and stigma towards mental illness (CDC, 2023; Kirby et al., 2019).

There are multiple suicidal risk factors that have been studied by researchers, but none have been able to determine why these risk factors may be different for individuals with and without autism. Recently, some researchers have suggested that being autistic, sometimes referred to as the autistic genotype, is a risk factor for suicidality due to co-occurring depression and lack of social interaction and/or higher education (Warrier & Baron-Cohen, 2021). Autism traits exist throughout the general population, and are not considered a clinical ASD diagnosis (Hedley et al., 2021). However, some researchers have suggested that specific autistic traits (e.g., need for sameness, rigidity, social communication challenges) are associated with anxiety, depression, and suicidality (Stanley et al., 2020).

Using the four categories of individual, relationship, community, and societal risk factors, the CDC (2023) also provides suggestions for protective factors. Individual protective factors

include good problem-solving skills and reasons for living as well as feeling connected and supported by family and friends for protective relationship factors (CDC, 2023). Sense of connection is also a protective factor for community as well as quality healthcare. Kirby et al. (2019) found in their 20-year study that individuals with autism in Utah, USA, were less likely to use firearms for suicide compared to non-autistic individuals. The societal protective factors include reducing access to lethal weapons and moral and / or religious beliefs against suicide (CDC, 2023). Hirvikoski et al (2020) suggests many approaches towards prevention including suicide risk assessment, social support, and access to mental health care. The high prevalence of suicide continues in the autism community because the needs of the individuals with autism are not addressed.

Statement of the Problem

The problem addressed in this study was the lack of individualized information about suicidality and the impact it has on the high prevalence of suicidality with level one autism spectrum disorder (ASD) adults. Being autistic and having different mental health experiences than those who are non-autistic means that suicidality is also looked at differently. There are multiple risk factors to help explain why an individual with autism may commit suicide but there is a lack of understanding as to why these occur (Dow et al., 2021; Nyrenius et al., 2023; Pelton et al., 2023). The Interpersonal Theory of Suicide (ITS), used as a framework for this study, has three major components that must be present for suicide to occur: thwarted belongingness, perceived burdensomeness, and acquired capability (Joiner, 2005; Joiner et al., 2009). This theory explains why suicide occurs, remains prevalent, and works well with the characteristics of ASD (Newell et al., 2023).

More attention is needed to support the autism community on the issue of suicidality. A recent pooled prevalence of 34.2% (95% CI 27.9–40.5) for suicidal ideation and 24.3% (18.9–29.6) for suicidal attempts and behaviours was reported from a meta-analysis of more than 48,000 participants with ASD and possible-ASD (Newell et al., 2023). Individuals with autism who experience suicidality need healthcare professionals to address their medical and mental health care needs (Cleary et al., 2023). Employment professionals need education about autism and suicidality in order to help prevent suicides in the future, save lives, and lower the prevalence of suicides (Curtis, 2022). Awareness about risk factors of suicidality for autistic adults, encourages prevention, and begins to lower the prevalence of autistic suicide.

Purpose of the Study

The purpose of this qualitative, phenomenological study was to evaluate individualized information about the factors that have led to a high prevalence of suicidality in adults with level one autism spectrum disorder. In-depth interviews were used to learn about the phenomenon of the individual with level one autism who had experienced suicidal risk factors and suicidality. Interviews with therapists took place over phone recordings who shared their client's lived experiences. Using the Interpersonal Theory of Suicide (ITS) framework allows the participants' lived experience to be understood regarding thwarted belongingness, perceived burdensomeness, and acquired capability, the three major components of the ITS theory (Joiner, 2005).

Therapists who work with adults diagnosed with ASD were reruited through various autism research websites. This wass considered purposive sampling since it has inclusion criteria (e.g., autism diagnosis, over age 18) as well as convenience sampling since recruitment will be available through websites (Creswell, 2009). Snowball sampling will likely occur due to the

distribution of the flyer throughout websites (Creswell, 2009). There will be approximately 8-10 participants expected for this qualitative study which is supported by Moustakas (1994).

Semi-structured interviews were conducted through phone recordings for sixty to seventy-five minutes. Participants described the client's experience with suicidality and the factors that impacted their suicidality. Instrumentation included interview recordings, journal notes, and follow-up interviews, as needed for clarity in analysis and preventing participant fatigue (Peoples, 2021; Privitera, 2020). All recordings were transcribed, read, categorized, and coded as part of thematic analysis (Privitera, 2020).

Introduction to Theoretical Framework

The three categories of the Interpersonal Theory of Suicide (ITS; Joiner, 2005; Joiner et al., 2009) are: thwarted belongingness, perceived burdensomeness, and acquired capability. Losing one's sense of being a part of a group of friends or family that have stable and positive interactions is thwarted belongingness. Perceived burdensomeness is the perception that one is a burden to others, and there is no way to relieve that burden. Acquired capability is the ability to harm oneself to the point of suicide. All three categories need to be present in order for someone to commit suicide.

Researchers have found that the categories of the ITS are relevant to suicidality. Suicidal ideation is most common with both thwarted belongingness and perceived burdensomeness present (Chu et al., 2017; Dow et al., 2021). The ITS also states that when both thwarted belongingness and perceived burdensomeness are experienced together, it is typical for an individual to move toward suicidal desire, or wanting to die by suicide (Joiner et al., 2009). Using both participants with and without autism, Pelton et al. (2020) found that thwarted

belongingness and perceived burdensomeness could predict suicide attempts in some individuals with ASD.

Acquired capability, the third category of the ITS, must be present for one to get to the act of suicide. Acquired capability is when one has rehearsed, or practiced, to deliberately hurt oneself to commit suicide (Joiner, 2005). The presence of acquired capability can predict suicide attempts in both individuals with and without autism (Moseley et al., 2022). The combination of thwarted belongingness, perceived burdensomeness with suicidal desire, plans and preparations, and the capability to harm oneself, is the cumulative point of death by suicide (Joiner, 2005). The concepts of ITS and suicidality match closely and align well for research with autism.

This study adds to the existing knowledge of the Interpersonal Theory of Suicide by showing the lived experiences of adults with level one autism who have suffered through suicidality (Joiner, 2005). With the ITS, this study considered the impact of suicidal risk factors and the concepts of thwarted belongingness, perceived burdensomeness, and acquired capability for individuals with autism. Many of the same risk and protective factors found in individuals with autism are also found in individuals without autism (e.g., mental health issues, relationship challenges, lack of access to healthcare), according to the CDC (2023). There are many risk factors found in non-autistic adults that lead to a higher probability of suicide (Newell et al., 2023). Research has shown that individuals with autism have more life stress than individuals without autism due to depressed mood, lack of coping strategies, and suicidality (Pelton et al., 2023). Using the ITS as a theoretical framework allowed an understanding of the individuals who attempt suicide, specific factors related to suicide as well as the relevance to individuals with autism (Newell et al., 2023). Theoretical models, including ITS, have been unable to

explain why sometimes suicide occurs when the specific criteria are not met, or why suicidality does not develop even when the criteria are present (Joiner, 2005; Rugo-Cook et al., 2021).

Introduction to Research Methodology and Design (Nature of the Study)

The current study used a qualitative, phenomenological methodology to examine the factors of suicidality in those with level one autism spectrum disorder. Discovering the factors for suicidality and the lived experience of the participants allowed the researcher to use qualitative research methods. The purpose of using qualitative research was to focus on inquiry and exploration through interpretive means in natural settings, which aided in understanding the phenomena of the individual's experience (Denzin & Lincoln, 2018; Mertens, 2020; Nassaji, 2020). Participants for this study were to be video recorded from their natural setting (e.g., home, office). There are two approaches to qualitative methods: inductive and deductive. For this qualitative, phenomenological study, an inductive method was a logical choice with a focus on experiences and meaning from the participant's viewpoint. Unlike the deductive approach which looks for evidence to support pre-conceived ideas, the inductive method allowed the researcher to study and analyze participant responses for themes and patterns for meaning, allowing thematic analysis to occur (Kivunja & Kuyini, 2017).

Phenomenology is designed for the researcher to describe and understand the subjective point of view of the client who experienced the event, or lived experience. Phenomenology allowed the researcher to learn what and how individuals experienced and understand the world around them without making assumptions about their lives (Mertens, 2020; Neubauer et al., 2019). Similarly, phenomenology allowed the researcher of this study to learn, experience, and understand the client's experiences of suicidality. Interpretive, or hermeneutic, phenomenology is focused on literally interpreting the phenomenon, or the lifeworld of the participant (Neubauer

et al, 2019). There are three elements to hermeneutic phenomenology, according to Bynum & Varpio (2018): the focus on the lived experience of the client, the researcher's experiences in data and analysis, and the reflection and journal writing during the analysis. The lived experience of the client included their own background.

Martin Heidegger, with a background in theology and philosophy, began the idea of interpretive phenomenology, or hermeneutics. Heidegger believed that phenomenon is not just discovered, but must also be interpreted with one's past experiences, which included researchers when using hermeneutics (Neubauer et al., 2019). Similarly, this study will interpret the interviews from participants about the lived experiences from their client of suicidality, past and/or present. The values and experiences of a hermeneutic phenomenological researcher were not about the participant, client or the content, and are not considered as part of the analysis. For this study, the researcher maintained an ongoing record for reflection and journaling. This does not minimize the need for awareness of any personal bias, which was added to the data journal (Bynum & Varpio, 2018; Mertens, 2020).

Research Questions

RQ1

What are the experiences for individuals with autism when the risk factors for suicidality are present?

RQ2

What are the experiences of suicidality for individuals with autism?

RQ3

What suicidality factors are experienced by individuals with autism?

Significance of the Study

The significance of this study led to a deeper understanding of the specific factors that are present during the suicidality of adults with level one autism spectrum disorder (ASD), and an understanding of the impact of the high prevalence of suicide amongst individuals with autism. Participants provided information from their client's lived experiences as adults with level one ASD who have experienced suicidality that could reduce the prevalence of suicide (Stewart et al., 2023). By learning about the impact that the specific factors had on their incidents of suicidality, one positive consequence of the study was the participants give a unique perspective of their client's experiences. The experiences of the client's provided individualized information about factors, as mentioned in the problem statement, to build awareness and understanding of the best methods needed to support adults with ASD when experiencing suicidality.

This study supports those who work with adults with autism through psychoeducation about the experiences of suicidality. From the purpose statement, one benefit of the study was that individuals with autism who experience suicidality have clarity and understanding of the specific factors that trigger suicidality for them. This, in turn, encourages communication for support services to be received in a timely manner. The experiences of the client's will provide healthcare workers and clinicians resources for helping, working, and educating themselves about working with suicidality in adults with level one autism (Giannouchos et al., 2023, Jachyra et al., 2022.). This study provides understanding of the specific factors for individuals with autism, the impact, and to learn which factors lead to suicidality and which ones do not.

One important significance of this study was the voice of the individual with autism. This study adds to the importance of the voice of the individual with autism being heard in suicide risk assessments (Cassidy et al., 2021), suicide research and suicide prevention studies (Su &

Procyshyn, 2023). It is crucial that research studies on ASD and suicide discover and focus on risk factors, risk assessment, and treatment barriers (Cassidy et al., 2021; Su & Procyshyn, 2023). A significant outcome of this study was awareness to the society at-large about the impact of suicidality among adults with autism, which will decrease the prevalence of suicide.

Definitions of Key Terms

Term 1

Autism spectrum disorder - ASD is a lifelong neurodevelopmental disorder depicted by challenges with reciprocal social communication, sensory sensitivities, developing and maintaining relationships, and repetitive and/or restricted behaviors and interests, according to DSM-5-TR (APA, 2022).

Term 2

Non-suicidal self-injury (NSSI) – The intentional self-inflicted destruction of the body without suicidal intent (Cipriano et al., 2017).

Term 3

Risk factors – Factors that increase the possibility of suicide in four categories: individual, relationship, community and society (CDC, 2022).

Term 4

Suicidality – A broad term used to encompass the terms of suicidal ideation, suicidal attempts, and suicidal behavior (APA, 2018; Harmer et al., 2023).

Summary

Suicide and autism rates are increasing individually and together. The problem addressed in this study was the lack of information about risk and protective factors and the impact they

have on the high prevalence of suicidality in individuals with autism. In this qualitative, phenomenological research study, there was a need to evaluate the suicidal factors that lead to the high prevalence of suicidality in individuals with autism. In the last decade, research has shown the high prevalence of suicidality in individuals with autism (Hirvikoski et al., 2016; Kirby et al., 2019). There are many possible risk factors for suicidality in individuals with level one ASD, but there was a need to learn more about specific factors in order to help those with suicidality. Learning more about these factors and the lived experiences of the participants adds important research to what already exists.

Using the ITS as a theoretical framework allows an understanding of the people who attempt suicide, specific risk factors related to suicide as well as the relevance of ITS to individuals with autism (Newell et al., 2023). The ITS has provided a framework for looking at suicide in individuals who experience thwarted belongingness, perceived burdensomeness and acquired capability along with plans and predictions, and suicidal desire (Joiner, 2005; Joiner et al, 2009a). In addition, research has shown that individuals with autism experience the three categories of ITS providing an understanding of the experience of suicidality (Chu et al., 2023; Dow et al., 2021; Pelton et al., 2022).

Recruiting participants from various sites was the method of choice (Creswell, 2009). The researcher does acknowledge the challenges, mental health issues, risk factors, and behaviors that have led to why so many individuals with autism are choosing suicide (Cassidy et al., 2014; Newell et al., 2023). Thematic analysis was done through categorizing and coding to find themes based on participants' interviews. Results provided information for prevention plans and support services.

Chapter 2: Literature Review

The purpose of this qualitative, phenomenological study was to evaluate individualized information about the factors that led to a high prevalence of suicidality in adults with level one autism spectrum disorder (ASD). The problem was that there continues to be a high prevalence of suicide amongst individuals with autism in the last decade (Hirvikoski et al., 2016; Newell et al., 2023). A recent pooled prevalence of 34.2% (95% CI 27.9–40.5) for suicidal ideation and 24.3% (18.9–29.6) for suicidal attempts and behaviours was reported from a meta-analysis of more than 48,000 participants with ASD and possible-ASD (Newell et al., 2023). Awareness about risk factors of suicidality for autistic adults, encourages prevention, and begins to lower the prevalence of autistic suicide.

Research was gathered from peer-reviewed, full-text articles from databases which included EBSCOhost, Educational Resources Information Center (ERIC), ProQuest, Google Scholar, and PsycArticles. Research was compiled through information and research on the websites for the Centers for Disease Control (CDC), World Health Organization (WHO), National Institute of Mental Health (NIMH), Autism Self-Advocacy Network (ASAN), and the American Psychological Association (APA) which included statistics, basic facts, suicide intervention and prevention programs. Basic searches began with the year 2015 and gradually minimized to the year 2023. Topics included autism spectrum disorder, theories of autism, qualitative, suicidality, theories of suicide, risk factors, and suicide prevention. Advanced searches for the topic of suicide included the Interpersonal Theory of Suicide, the Three-Step Theory, Fluid Vulnerability Theory and the Motivational-Volitional Model of suicide as well as undated, seminal articles from Durkheim, Baumeister, Maslow, and Shneidman. Research on the theories of autism included the Theory of Mind, Social Motivation Hypothesis, Weak Central

Coherence, Executive Dysfunction, and the Diametric Model of Autism. Seminal articles from Kanner, and information on autism diagnoses from prior Diagnostic and Statistical Manual of Mental Disorders (DSM) editions were also researched. For the topics of research design and methodology, information on theoretical frameworks, qualitative studies, dissertations, and phenomenology databases and various books were used dating back to 2005.

The lack of information about suicidality and the high prevalence of suicidality with individuals with level one autism, is a problem. The purpose was to understand the lived experience of suicidality from individuals with level one autism. Using an individual's lived experience was the most honest way to understand what occurred (e.g., risk factors, ITS components), what they felt at the time (e.g., risk factors, ITS components), and what they felt in retrospect (e.g., risk factors, ITS components).

Theoretical Framework

Joiner (2005) created the Interpersonal Theory of Suicide (ITS) framework that helps us understand what leads one to commit suicide. ITS explains three main categories that an individual encounters when experiencing suicide: thwarted belongingness, perceived burdensomeness, and acquired capability (Joiner, 2005; Joiner et al., 2009a). Thwarted belongingness and perceived burdensomeness can exist together creating the experience of suicidal ideation. However, if at any point, suicidal desire and / or acquired capability become part of the individual's experience, the seriousness and potential for lethality increases (Joiner, 2005).

Thwarted Belongingness

The first category of the ITS is thwarted belongingness, or lack of belonging, which occurs when a person no longer believes they belong to a group or that the group accepts them. This is similar to Durkheim's social isolation position, or the feeling of no longer being a part of a group (Motillon-Toudic et al., 2022). Emile Durkheim, (1859-1917), a French sociologist who essentially founded sociology, believed strongly in the structure and norms of society. The author of *Suicide* (1897/1951), Durkheim found from his research that social isolation from a group can be a reason for suicide, and social connections can change based on the concepts of integration and regulation (Berkman et al., 2000; Mueller et al., 2021). Integration for Durkheim means close relationships amongst the group members which, in turn, give purpose and meaning to the individuals and the group. These close relationships are a protective factor from social isolation, or a lack of belonging (Mueller et al., 2021). Regulation for Durkheim refers to changes in social positions of individuals that can cause more issues, leaving numerous people dissatisfied to the point of suicide (Joiner, 2005). Thwarted belongingness, or lack of social connectedness, is believed to be a factor in suicide (Van Orden et al., 2010). Durkheim's work on society and suicide was unquestionably significant, even though it did not address individual suicidality concerns.

A sense of belonging is not just related to suicidality. Abraham Maslow (1954) wrote about the importance of belonging as part of his five-part hierarchy of basic needs: physiological, safety, belongingness, esteem, and self-actualization. Love and belonging are part of a reciprocal relationship that gives and receives friendship and companionship (Rojas et al., 2023). A sense of belonging is created from the culture, positive experiences, and people who impact one's identity and perceptions, just as lack of belonging is created from lack of purpose, lack of meaning, and negative life experiences which can affect mental and physical health (Allen et al.,

2021). Similarly, O'Connor (2011) showed in the Integrated Motivational-Volitional Model that factors which can be a deficit or deprivation from relationships, life events or one's environment may lead to suicidal ideation in the pre-motivational phase of his theory (O'Connor, 2011; O'Connor & Kirtley, 2018). Experiencing both pain (including psychological pain) and hopelessness can lead to suicidal ideation, which can increase if one's sense of connectedness causes more pain, according to the Three-Step Theory of Suicide (3ST: Klonsky & May, 2015). Baumeister and Leary (1995) suggested that people need interactions with the same individuals that are both positive and caring. Comparably, Joiner (2005) believes that the feeling of being cared about as well as a sense of belonging help prevent suicidal desire. When experiencing loneliness individuals might feel the disconnection and absence of their reciprocal relationship, have the sense of thwarted belongingness, which could possibly lead to suicidal ideation (Van Orden et al., 2010).

Perceived Burdensomeness

The second category of the ITS framework is perceived burdensomeness which occurs when a person believes they have become a burden to others, usually family or friends. "Perceived" is a term that Joiner (2005) uses distinctly to explain that these are often mistaken perceptions by the suicidal individual. Perceptions of believing the individual is a burden, believing this issue is permanent, and death is the only solution. The perceived failure of the individual is believed to permanently have shame, pain, and suicidal thoughts, and the sense of thwarted belongingness.

With a desire for suicide, there are two other elements of perceived burdensomeness: thoughts of self-hatred and self as a liability (Van Orden et al., 2010). The sense of

burdensomeness can be overpowering for the individual experiencing it. In fact, self-hatred is not uncommon for the suicidal individual to believe that life would be better without them (Joiner, 2005). Autistic adults often have experiences which can lead to severe perceived burdensomeness (self as a liability), and social anxieties which can lead to lack of belongingness, both creating potential risk factors for suicidality (Dow et al., 2021; Pelton et al., 2023). Experiences of perceived burdensomeness include incarceration (Fazio et al., 2012), unemployment (Espeloer et al., 2022), and physical illness (Hirvikoski et al., 2016).

Acquired Capability

The third category of the ITS framework is acquired capability, or acquired ability, which occurs when an individual is able to lethally harm themselves. The Interpersonal Theory of Suicide states that it takes more than just the desire to die by suicide (Van Orden et al., 2010). First, one must lose the fear of dying and, if necessary, the fear of dying by suicide (Joiner, 2005). Next, one needs to increase their pain tolerance since suicide is both scary and painful. By the time one attempts suicide, the pain is always tolerable, and there are multiple case examples to show this (Joiner, 2005; Van Orden et al., 2010). Then, the concept of acquired capability is created by habituation and the opponent process (Solomon & Corbit, 1974). Finally, one may experience pain or provocative experiences which may allow capability to be acquired faster (Joiner, 2005).

Losing the fear of harming oneself is a process that takes time and practice (Joiner, 2005). If one's pain tolerance is increasing because the individual is harming themselves often, then the fear of harming oneself through suicide is decreasing (Joiner, 2005; Van Orden et al., 2010). In addition, one must acquire the ability for suicide by creating a habit of harm, or

habituation, to create little or no fear or pain (Joiner, 2005). This can occur in many ways, including self-harm, attempted suicides, and or painful and provocative experiences (Joiner, 2005). The 3ST states that an individual can shift from suicidal ideation to suicidal attempt due to factors that increase their dispositional, acquired, and practical capability for suicide (Anderson & Happ, 2021; Klonsky et al., 2021). These include low pain tolerance, low harm avoidance, controlling the impulse to self-harm, habituation, and access to lethal means (Klonsky et al., 2021). Pain, hopelessness, and lack of connectedness can all act together leading to suicidal ideation and intensifying into a suicidal attempt (Pachkowski et al., 2021).

Similarly, in the third step in the IMV (O'Connor, 2011), suicidal ideation and intent may or may not lead to suicidal behavior with volitional moderators. Examples of volitional moderators that may increase or decrease risk include planning, pain sensitivity, fearlessness about death, and access to means. The volitional phase, the third category, is when the individual is experiencing suicidal behaviors. The updated version of IMV (O'Connor, 2018) added that individuals who have already attempted suicide would not return to the first category, but would only return to the suicidal ideation and intent phase. Suicide ideation which had occurred in the past year with individuals with autism also experienced depression, perceived burdensomeness, and suicide plans, according to Moseley et al. (2022). Those who had attempted suicide however, had stronger feelings of burdensomeness, high risk of suicide, and lower fear of death showing the progression made through the ITS framework (Joiner, 2005).

The opponent process theory occurs with habituation as part of acquired capability. There are two opposing processes occurring over a repeating (or habituating) event (Solomon & Corbit, 1974). Using self-injury as an example, the first emotion when hurting oneself may be fear, but after the event, the second emotion may be relief or excitement. When the self-injury is

repeated, the first emotion, fear is lessened and the second emotion, relief or excitement is exponentially increased, allowing the fearful event (self-injury) to continue to be repeated (Joiner, 2005). Thus, the opponent process with habituation can lead to acquired capability, and suicide (Van Orden et al., 2010). Lastly, painful and provocative experiences are considered an element of the acquired capability category since they are considered to already be frightening, painful, and/or habitual, allowing a higher risk of suicide. Painful and provocative experiences may include childhood maltreatment, combat exposure, previous suicide attempts, and/or family history of suicide (Van Orden et al., 2010). Although acquiring the capability for suicide can be from practicing suicidal behaviors or aborting an attempted suicide, unfortunately, suicidal attempts are still the most lethal (Joiner, 2005; Van Orden et al., 2010).

The 3ST and IMV theories presented have similar steps and characteristics to the Interpersonal Theory of Suicide: belongingness, burdensomeness, and capability. There are multiple similarities between the Three-Step Theory of Suicide and the Interpersonal Theory of Suicide (Joiner, 2005; Klonsky & May, 2015). Klonsky & May's (2015) concept of connectedness is very similar to Joiner's (2005) sense of low belongingness and high burdensomeness as well as the concept of capability. In addition, there are many similar examples of capability to commit suicide that both theories share (e.g., low pain tolerance, self-harm, habituation, access to lethal means). The IMV uses three categories and only a few of the same terms as the ITS (e.g., thwarted belonging and burdensomeness), as well as researchers who have used individuals with autism or autism traits as participants (e.g., Cassidy, Gould et al., 2020; Cassidy et al., 2023; Moseley et al., 2022; Pelton & Cassidy, 2017). Otherwise, there are not many similarities between the ITS and IMV theories (Joiner, 2005; O'Connor, 2018).

The ITS differs from the seminal theories of suicide who all explained suicidality as having one trait: Durkheim (1897/1951: social isolation), Baumeister (1990: escape from pain), Beck (hopelessness) and Shneidman (1985, 1993: psychache). By using acquired capability as a step past suicidal ideation toward suicidal attempts, the ITS created a new way to consider suicidality. This cohort of theories are referred to as the ideation-to-action theories (Joiner, 2005; Klonsky et al., 2018).

There is one significant difference between the 3ST and the ITS. The concept of connectedness for Klonsky & May (2015) is positive, and expected to be protective against suicidal ideation especially for those with high levels of pain and hopelessness. For the ITS, protective factors are absent suicidal traits or factors that will not lead to one of the three categories. For example, the fear of suicide can be a protective factor since suicidal desire and acquired capability would be absent and not occur (Joiner et al., 2009a). An individual does not need to have disrupted connectedness to have suicidal ideation, just as it is not required for an individual to have suicidal ideation from experiencing disrupted connectedness (Klonsky & May, 2015).

The Interpersonal Theory of Suicide and Autism

All three categories of the Interpersonal Theory of Suicide have been developed, and research supports its efficacy with individuals with autism (Cassidy, Gould et al., 2020; Moseley et al., 2022; Pelton & Cassidy, 2017). For example, individuals with autism have been known to use camouflaging to hide their autistic traits, leading to high levels of stress and anxiety (Cage & Troxell-Whitman, 2019; Cassidy, Gould et al., 2020). Camouflaging, or hiding or attempting to hide autistic traits from others, is commonly found in individuals with autism. Cassidy, Gould et

al. (2020) found that camouflaging can threaten one's sense of belonging, and lead to thwarted belongingness and suicidality across the lifespan (Cremone et al., 2023; Joiner, 2005). This risk factor, camouflaging, is an example to show that individuals with autism can experience the categories of the ITS framework which help explain suicidality (Joiner, 2005).

One reason the ITS was the best framework for this study was the connections that have been made between individuals with autism and suicidality. It has actually been proven that thwarted belongingness and perceived burdensomeness lead to suicidal ideation, and together with acquired capability and desire to die, suicidal behavior can be predicted (Chu et al., 2017; Joiner et al., 2009b; Perez et al., 2023). Individuals with autism often deal with many life stressors leading to an inability to cope, a sense of hopelessness, and suicidality (Pelton et al., 2023; Perez et al., 2023).

The focus of the ITS is on understanding the process of suicide, in order to help those experiencing suicidality, and increase prevention (Joiner, 2005). This leads to lessening the impact on the prevalence of suicide amongst level one adult individuals with autism. Joiner (2005) explains the differences between suicidal ideation and suicidal attempts, and offers suicidal desire and capability as necessities for lethal suicide. In a positive way, one begins to understand the process one may go through while contemplating suicide (Joiner, 2005; Joiner et al., 2009a). The ITS is a strong framework for this study because it assists clinicians and healthcare professionals in having more understanding of suicidality, and supporting families with an understanding of the loss of a loved one to suicide (Joiner, 2005).

History of Autism Spectrum Disorder through the DSM-III to DSM-V-TR

From the mention of the term “autism” by Paul Eugen Bleuler at a conference in 1908 to the 1980s, there were significant changes and progress made toward a diagnostic definition which established autism as its own condition for the DSM-III (APA, 1980; Ashok et al., 2012; Golt & Kana, 2022). Over time, revisions to the DSM brought changes to the diagnostic criteria for autism in each new version (Golt & Kana, 2022). The seminal works of Kanner (1943) and Asperger (1944) reflect the heterogeneity of the diagnosis of autism spectrum disorder today (DSM-V-TR: APA, 2022; Asperger, 1944; Golt & Kana, 2022; Kanner, 1943).

Early History

Autism spectrum disorder has been recognized since the term “autism” was first used in 1908 at a conference by Paul Eugen Bleuler, a German psychiatrist, to describe patients with schizophrenia who showed symptoms of being remote and detached (Ashok et al., 2012; Golt & Kana, 2022). The history of autism as a disorder began in 1943 with Leo Kanner, a psychiatrist from John Hopkins University, who observed and documented 11 children who had severe issues, similar to today’s autism spectrum disorder (DSM-V-TR, 2022; Golt & Kana, 2022). The children had problems that included issues with social interaction, connectedness, resistance to change or a need for sameness (Golt & Kana, 2022; Rosen et al., 2021). Across the globe in Austria in 1944, Hans Asperger, a pediatrician, was also noting boys who had restricted interests, strong verbal skills, and poor socialization (Rosen et al., 2021). However, Asperger’s work was not well recognized until the 1980s, until Lorna Wing referred to a group of children fitting Asperger’s description of issues with social interactions, precocious language, social isolation, and above-average language skills (Barahona-Correa & Filipe, 2016; Wing, 1981).

Kanner (1943) and Asperger (1944) brought clear and important research to the understanding of autism. Kanner (1943) found a need for sameness, communication issues, and echolalia in his patients, similar to what is found today in autism spectrum disorder (Rosen et al., 2021). In addition, Kanner noted biological differences in children with autism, focusing on the developmental aspect of autism (Golt & Kana, 2022; Rosen et al., 2021). Asperger (1944) found intense interests, high performance cognitively, social isolation, and lack of motor coordination, similar to what is found today in the former Asperger's Syndrome (DSM-IV, APA, 1994; Golt & Kana, 2022). Both Kanner and Asperger believed that individuals with autism were cognitively different, not because there was a problem with thinking, but to show that autism was not mental retardation or intellectual disability (Baker & Lang, 2017; Golt & Kana, 2022).

Kanner's Controversies

There were at least two significant controversies around Kanner. The first came with Kanner (1943) and his reference to the term, "refrigerator mothers". This term meant that mothers of children with autism were cold, unfeeling and detached, leading to a great deal of angst and stigma for parents (Golt & Kana, 2022). Later, in 1967, Bruno Bettelheim, in his beginning theory of autism, emphasized "refrigerator mothers" as the cause of autism. This theory was later refuted, originally by Bernard Rimland (1964; Golt & Kana, 2022). The second controversy occurred over whether or not Kanner knew of Asperger's work before publishing his report in 1943 (Silberman, 2015). There is evidence that shows that this is possible, due to the immigration of Georg Frankl to the US to work with Kanner (Czech, 2018; Silberman, 2015). Although both men were researching autism, their findings were different: Kanner's focus was more developmental whereas Asperger's focus was more towards a personality disorder (Rosen et al., 2021).

Asperger's Controversy

The biggest controversy of Asperger's work is the connection with the Nazi regime during World War II. In 1938, Austria was annexed into Nazi Germany, referred to as the Anschluss, or political union (Britannica, 2024). Between 1939 and 1945, World War II raged through Europe and Asia, involving the rest of the world (Czech, 2018). Two of Asperger's closest colleagues were Erwin Jekelius and Franz Hamburger, both very open Nazis (Czech, 2018). Dr. Hamburger, who was very anti-Semitic, was chair of the pediatric clinic where Asperger worked (Czech, 2018; Sher, 2020). Dr. Jekelius would become the leader of Am Spiegelgrund hospital, where thousands of deaths of disabled children and psychiatric patients occurred (Czech, 2018; Sher, 2020).

Hans Asperger was a part of the Nazi regime through many organizations, referred children to the "euthanasia" program (run by Jekelius) at Am Spiegelgrund hospital, and openly permitted race hygiene, such as forced sterilizations (Czech, 2018; Sher, 2020). There are multiple examples from archival material showing Asperger's recommendations and notes about children being sent to Spiegelgrund or Gugging psychiatric hospital to be handled by Dr. Jekelius (Czech, 2018; Sher, 2020). Children labelled "encephalitic", "uneducable", or "unemployable" were essentially being given their ticket to "euthanasia", although their death certificate would state pneumonia (Czech, 2018). Just as horrible was when Asperger would add if a patient was Jewish or 'Mischling' (one Jewish parent), which during this anti-Semitic era, was also a death sentence (Czech, 2018; Sher, 2020).

In addition to the multiple artifacts showing what Asperger wrote, numerous professionals have written papers and books in his defense. In "Asperger and his syndrome", Uta

Frith's 1991 book chapter, barely mentions National Socialism. Instead, she writes about how he cared about children, defending them and putting himself at risk (Frith, 1991). Additionally, Helmut Groger in 2003 cited 23 of Asperger's writings, stating that Asperger avoided race ideology, and advocated for his patients (Groger, 2003). In any debate, there is a point where it is difficult to choose which side to take. In this situation, however, it seems to be about the autism community, and the additional stigma that they must face from Asperger's questionable ethics (Sher, 2020).

Diagnosing Autism

There were some notable events that occurred to help develop a diagnosis of autism from the mid-1960s through the 1980s. Rutter et al. (1969) noticed the range of difficulties children were having that needed a diagnosis for developmental and medical problems that were not present in DSM-II (APA, 1968). Rimland (1964/1968) created a diagnostic checklist of symptoms of autism to differentiate from schizophrenia. Also, a new definition of autism was developed that included early onset of delayed language development, repetitive behaviors, and restrictive interests from Rutter (1978). This definition included hypo- and hyper-sensitivities to environmental stimuli, unusual rates of development that were added in by the American National Society for Autistic Children (Ritvo & Freeman, 1977). This was for the upcoming DSM-III (APA, 1980; Rosen et al., 2021). Then, autism was found to be genetic in monozygotic twins, which discredited the "refrigerator mother" theory (Bettelheim, 1967; Folstein and Rutter, 1977). Finally, research showed that children with autism responded to structured teaching strategies better than the unstructured therapy for schizophrenia, supporting the idea that autism was not schizophrenia (Bartak and Rutter, 1973). All of these elements together showed that

autism was a diagnostic condition of its own, and was finally included in the Diagnostic and Statistical Manual (DSM-III, APA, 1980; Rosen et al., 2021).

DSM-III and DSM-III-R

The DSM-III (APA, 1980) created many changes and additions from past editions but, in regard to autism, it was all new. A new category of Pervasive Developmental Disorders (PDDs) was created, and infantile autism was finally included in the DSM for the first time (APA, 1980). Criteria for a diagnosis of autism included lack of social interaction, including a residual category for those who had later onset (Rosen et al., 2021). The estimated prevalence was very low, and autism was considered rare, since only seven in 10,000 children were diagnosed (Fombonne, 1999). Receiving an autism diagnosis was not easy since the patient had to meet eight of 16 criteria (DSM-III, APA, 1980). A few challenges did become apparent quickly for the new autism category. Specifically, the requirement for all criteria for autism to be met was very restrictive as well as no recognition for adults with autism due to the infantile label (DSM-III, APA, 1980; Rosen et al., 2021).

The publishing of the DSM-III-R (APA, 1987), however, brought a significant change: “infantile autism” was replaced with “autistic disorder” allowing older children and adults to be included in diagnosis. In addition to the name change, the 16 criteria were modified for flexibility and use across age levels (Waterhouse et al., 1993). The diagnostic criteria were still in three categories: difficulties in communication, difficulties in reciprocal social interaction, and restricted interests, repetitive movements, and/or resistance to change (APA, 1987; Wing, 1981). In addition, the required eight criteria were now two from the social category, and at least one

from the other two categories (APA, 1987; Rosen et al., 2021). These changes allowed clarity for clinicians when diagnosing autism disorder (APA, 1987).

DSM-IV

Next was the work for DSM-IV (APA, 1994), which involved collaborating with the World Health Organization's International Classification of Diseases, 10th edition (ICD-10), due to changes that were made to their methods (WHO, 1992). A different process was used for the DSM-IV that included literature reviews, data analyses, work groups, and field trials (Volkmar et al., 1994). The three category diagnostic criteria for autistic disorder continued to be used due to its match with the ICD-10 structure, and fewer criteria were required for an autistic disorder diagnosis from DSM-IV (APA, 1994; Rosen et al., 2021). A separate diagnosis of Asperger's disorder was included with strong documentation to prove differences from autism and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS). There was some noted controversy regarding differences from Asperger's original findings as well as information about final editing without committee approval at production time for the DSM-IV (APA, 1994; Golt & Kana, 2022; Rosen et al., 2021).

The Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS) classification was added in DSM-IV to capture autistic traits not classified as autism spectrum disorder (APA, 1994). The addition of PDD-NOS was to show that an individual may have autistic traits but not qualify for an autism spectrum disorder diagnosis (APA, 1994; Golt & Kana, 2022). The DSM-IV added Rett Syndrome, atypical autism, autistic disorder, Childhood Disintegrative Disorder (CDD), and Asperger Disorder to the PDD classification (Golt & Kana, 2022). There was research showing autism was brain-based, due to its connection to seizures

(Volkmar and Nelson, 1990). Finally, it was decided that autism disorder was not part of the over-arching classification of PDD and should be in a class by itself (Golt & Kana, 2022; Wing, 1997).

DSM-V and DSM-V-TR

A significant change from DSM-IV to DSM-V was the change of the terms "autism disorder" to "autism spectrum disorder" (APA: 1994, 2013). The new focus of DSM-V shows severity levels of autistic symptoms based on the individual's need for support for basic functions (e.g., level two = needs substantial support) as well as specifiers that include other impairments, such as medical conditions (APA, 2013; Rosen et al., 2021). In addition, the traditional three-category classification was reduced to just two categories (DSM-V, 2013; Golt & Kana, 2022). Deficits in language and communication and social interaction in DSM-IV became "Problems with Social Communication" in DSM-V as well as restricted interests and/or repetitive movements (APA: 1994, 2013).

A standard for the age of the onset of autism symptoms was added to DSM-V after its removal in DSM-IV (APA: 1994, 2013; Golt & Kana, 2022). Using a developmental perspective, the DSM-V allows an individual to meet criteria presently or in the past, since not all symptoms occur at specific ages or stages (APA, 2013; Rosen et al., 2021). DSM-V also incorporates broad principles to replace the examples that existed in DSM-IV, which provided information on behaviors, such as peer interactions (APA: 1994, 2013; Rosen et al., 2021). These new principles provide information on deficits across developmental and age ranges (Rosen et al., 2021). The DSM-V-TR did not have significant adjustments to the category of autism spectrum disorder except for text revision to criterion A (APA, 2022a). The wording was

changed to “as manifested by all of the following” from “as manifested by the following” for clarity (APA: 2022a, 2022b).

There continues to be very little support on gender bias issues from any of the manuals until DSM-V mentions that females with autism may go unrecognized due to more understated discrepancies in communication and social issues (APA, 2013; Haney, 2016). Females have been found to be better at sharing interests, reciprocal conversation, and modifying their behaviors, but still have challenges with social understanding the same as males with autism (DSM-V-TR, APA, 2022). Females have been found to use social skills, like camouflaging, especially those who have higher cognitive skills (Cage & Troxell-Williams, 2019; Gillberg, 1993; Mattila et al., 2007). Evaluating the factors that females display, such as camouflaging, needs to be part of the autism diagnosis (Suckle, 2020). Females with autism are diagnosed later than males with autism perhaps because they do not actually fit the DSM criteria, or perhaps a new female autism phenotype is the answer, as Hull (2020) suggests.

Autism has changed over the last several decades by name, by definition, and by diagnosis (Williams, 2021). The diagnosis of childhood schizophrenia, a rare childhood disorder with intellectual disability with one original cause changed to a more common, widespread, lifelong disorder with a complex origin: autism spectrum disorder (Happé and Frith, 2020). Yet there are similarities between Kanner’s (1943) notes about the need for sameness, connectedness and awkard social interactions to today’s diagnostic criteria in the DSM-V-TR (APA, 2022; Golt & Kana, 2022; Rosen et al., 2021). Important research on autism spectrum disorder continues in many areas besides psychology and neurology as new ideas are transformed into valuable information.

Theories of Autism Spectrum Disorder

Autism has had a place in psychology for more than 80 years (Golt & Kana, 2022). Cognitive theorists believed in the 1990s that there must be a deficit in the thought processes and communication of individuals with autism (e.g., Ozonoff et al., 1991: executive dysfunction; Vivanti & Messinger, 2021). Multiple studies and theories were created to support these ideas, and many were challenged later (Peterson & Wellman, 2019; Williams, 2021). Over time, the stigmatizing belief that something was wrong with one's brain if diagnosed with autism led to the neurodiversity movement of today (Pellicano & den Houting, 2022; Rocha Araujo et al., 2023).

In the 1980s, several cognitive researchers proposed theories on the symptoms of autism spectrum disorder that allowed a preponderance of data to come forward (Vivanti & Messinger, 2021). The majority of these theories used the traditional medical model, proposing that individuals with autism had a primary cognitive deficit which explained their symptoms and behaviors (Vivanti & Messinger, 2021). A few of these theories included theory of mind (Baron-Cohen, 1990), executive dysfunction (Ozonoff et al., 1991), and weak central coherence (Frith, 1989). Since these theories are all cognitive deficit theories, some research covers more than one theory (e.g., Alamdari et al., 2022; Ozonoff et al., 1991; Pellicano, 2010). Social motivation theory is also significant as many theories of autism are based on the abilities of social interaction and social communication for the individual with autism (Chevallier et al. (2012). Lastly, the perceptions, discrimination, and bias that have existed around neurodiversity, specifically autism, are beginning to change. The emerging information about neurodiversity and the impact it is having on the communities of neurodivergent individuals is finally being seen around the globe.

Theory of Mind

Theory of mind is the idea that one has the ability to understand another person's intentions and beliefs, allowing one to respond appropriately in conversation (Chiu et al., 2023; Corbett et al., 2016). Theory of mind is also part of social cognition which addresses how one processes behaviors in social settings (Frith, 2008). Social cognition includes the identity and recognition of facial expressions, and how they are interpreted (Frith, 2008). Theory of mind is believed to be necessary for children in order to have positive interactions with others. Theory of mind development in children at 3 years old means children are able to recognize others' emotions, but children with autism are often not able to do this well (Baron-Cohen, 1985; Happe, 1994). Later, children begin to understand more nuances of language and communication, but children with autism around the ages of six to eight years old have shown insufficient development in this area by not recognizing sarcasm, jokes, and metaphors (Baron-Cohen et al., 1985; Happe, 1995/2009).

The theory of mind has had numerous studies challenged in various ways (Williams, 2021). Sometimes individuals without autism have been found to be unsuccessful at interpreting other people's emotions or intentions as seen in theory of mind (Baron-Cohen, 1990; Brewer et al., 2016; Heasman & Gillespie, 2018). Sometimes individuals with autism have been found to have high levels of effective communication with other individuals with autism, challenging the theory of mind (Crompton et al., 2019; Heasman & Gillespie, 2018). Sometimes individuals with autism have been found to perform better on explicit theory of mind tasks, including advanced level tests (Happe, 1995; Senju, 2013). Sometimes the implicit theory of mind tasks are challenging for individuals with autism, including the gaze patterns (Zhou et al., 2019) and emotional perceptions (Rosello et al., 2020; Uljarević and Hamilton, 2013). Similarly, Pellicano

(2010) found individual differences in executive function skills that influenced theory of mind skills when doing a longitudinal study on executive function, weak central coherence, and theory of mind with individuals with autism. Following the same pattern, Isaksson et al. (2021) found no relationship between theory of mind and executive function. Finally, Holt et al. (2020) found that sometimes the theory of mind concept, based solely on observed behavior, did not truly reflect the lived experiences of individuals with autism, and therefore has led to many presumptions about how people feel about the theory of mind.

Some researchers doubt the theory of mind, and believe that individuals with autism can participate equally in conversations (e.g., Peterson & Wellman, 2019). In their longitudinal research, Peterson & Wellman (2019) found that the deaf, autistic and typically-developing children did, in fact, make progress through the stages of theory of mind as they matured through their school years. Children with autism made progress, just not in the same way or at the same rate as shown in past research (Baron-Cohen, 1985; Happe, 1994). To understand cognitive mechanisms in communication, relevance theory has been used to learn about pragmatic language and impairment, such as smiling, knowing what to say, and how to say it (Happe, 1993). In addition, the relevance theory, an idea of shared expression, was used to create understanding between individuals with and without autism (Happe, 1993; Johnson, 2024). Theory of mind is not just about individuals with autism, but about all individuals (Milton et al., 2022).

Executive Dysfunction

Executive function was first related to the frontal cortex and frontal lobes of the brain when it was learned that skills, such as organization, planning and self-control, were also related

to this part of the brain (Stuss, 2011). The belief is that individuals with autism have executive dysfunction because they are unable to complete tasks, such as planning ahead, creating strategies, and being goal-oriented, due to overwhelming autistic characteristics, such as perseveration and rigidity (Hill, 2004). Individuals with autism have specific problems with executive functions, such as adjusting to new places, controlling inappropriate behaviors, perseveration, and understanding expectations, which can lead to issues with employment and authority figures in general (Davies et al., 2024a). In a comparative study between individuals with autism and individuals with schizophrenia, Yon-Hernandez et al. (2023) found that social awareness, insight, and abstract thinking could be challenging for individuals with autism as well as initiating goal-planning strategies, or executive function. Yon-Hernanez et al. (2023) found that by studying daily living skills it could show if there was poor adaptive behavior when working with individuals with autism and individuals with schizophrenia.

Executive functions are also higher-order thinking processes which include goal-oriented behaviors, strategy formation, set-shifting, and future planning (Baggetta & Alexander, 2016; Demetriou et al., 2019; Ozonoff et al., 1991). Cognitive flexibility, also known as set-shifting, is the competence to change ideas or actions in any given situation (Hill, 2004). For example, if an individual with autism was intently focused on watching their twirling hands (stimming), the belief is that they would be unable to be cognitively flexible to make changes to ideas or actions (Hill, 2004). The issue is that inflexibility occurs when one is perseverating, or having difficulty controlling behaviors common in autism (Hill, 2004). The cognitive inflexibility, the inability to switch to another task, such as making changes to specific actions or ideas, is the executive dysfunction (Demetriou et al., 2019; Ozonoff et al., 1991).

Weak Central Coherence

Having a weak central coherence is another cognitive deficit theory of autism, based on how one processes information (Frith, 1989). Central coherence theory regularly has described both exceptional aptitudes and deficits in individuals with autism, perhaps based on the type of test given (Happe & Frith, 2006; Bojda et al., 2021). If one tends to pull information together for the overall concept, or globally, then there is a strong central coherence (Happe, 1999). However, if one is more prone to only looking at the finer details of a situation, and not being able to look at the overall idea, they are said to have a weak central coherence (Hill, 2004). Levels of central coherence do not seem to change, like the significant changes found in both theory of mind and executive function in individuals with autism (Pellicano, 2010). Nonetheless, there continues to be ongoing research about the relationship, or lack thereof, between theory of mind and a weak central coherence (Bojda et al., 2021).

Social Motivation Theory

Young children with autism spectrum disorder are often less interested in social relationships from a very young age, according to Chevallier et al. (2012), who was first to write about the social motivation theory. Social motivation can affect social behaviors. However, the social motivation theory does not stop with young children, but continues into adolescence showing a lack of interest in social relationships or even social exchanges (Chevallier et al., 2012; Morrison, 2020). There are studies, however, that have shown that adolescents and adults with autism are, in fact, interested in relationships and friendships (Mazurak, 2014; Whitehouse et al., 2009). Preferring not to have social relationships, however, is not as damaging as attempting to conform to expectations through camouflaging, or masking, and trying to make social behavior appear more acceptable (Cage & Troxell-Williams, 2019; Cassidy et al., 2020).

Camouflaging can cause serious mental health issues, and even lead to suicidality (Cassidy et al., 2020).

Neurodiversity

The human brain can develop in many different ways, both physically and functionally, and this variety in neurobiology that exists all over the world is referred to as neurodiversity (Pellicano & den Houting, 2022). Neurodiversity, originally used by Singer (1998), includes both 'typical' brain development, and development that 'diverges', or does not fit the 'norm' (Jumah et al., 2016). Neurodiversity is also a social and political movement that stands for positive public policies, like school inclusion, especially for those with disabilities (Rocha Araujo et al., 2023). The neurodiversity paradigm moves away from the deficit medical model, providing positive information and acceptance of neurological disorders like autism and dyslexia, and follows two assumptions (Walker, 2012). First, neurotypical development is neither superior nor inferior to neurodiverse development (Pellicano & den Houting, 2022; Walker, 2012). In fact, diversity is as valuable in neurodevelopment as it is in other global areas, such as the intricacy of biomes in environmental science. Second, all people deserve to be treated with respect and dignity regardless of their diversity, which also supports better mental health overall (Cage et al., 2018; Walker, 2012).

Neurodivergent, the opposite of neurotypical, is in opposition to the social model of disability, which has been credited to Kassiane Asasumasu, an autism activist (Fletcher-Watson, 2020). The term includes all differences with distinct neurological patterns, such as dyslexia, epilepsy, ADHD and bipolar disorder (Baker, 2011). Neurodiversity follows the biopsychosocial model showing that autism evolves from behavioral and neurobiological paths to form

personality (Gillespie-Lynch et al., 2017; Pellicano & den Houting, 2022; Rocha Araujo et al., 2023). In the medical model, the general understanding is that there is a cure for autism, since it is a disease or disorder (Fuller, 2017). Perhaps in the future, autism will be considered a discarded disorder of DSM publications in which there is no disorder or cure, only a disadvantage or prejudice, such as homosexuality or left-handedness once were (Rocha Araujo et al., 2023).

One concern about the neurodiversity movement is for individuals with autism who need medical and /or psychological care (Jaarsma & Welin, 2012). Parents of children with autism who need a high level of care often feel that neurodiversity does not address their needs, especially if challenging the treatment plan is the goal (Dekker, 2020). Another concern is the genetic science movement that wants to use pre-natal screenings to find autism, as if it is to be considered a genetic flaw. Adults with autism were surveyed about their thoughts about genetic testing for autism, and most had concerns about it for their families (Byres et al., 2023). Pre-natal testing for autism could potentially lead worried parents towards abortion (Kapp et al., 2013; Rocha Araujo et al., 2023). One of the goals of neurodiversity is to encourage social pride amongst individuals with autism and other neurological disorders, to recognize them as a minority, as part of the social community (Rocha Araujo et al., 2023), and not fear or eliminate individuals with autism. Individuals with autism and their families who support the neurodiversity movement can be involved in the training of researchers and teachers of autism (Rocha Araujo et al., 2023). Neurodiversity can continue to grow and expand as a movement as autism diagnoses for both children and adults continues to increase.

Adult Autism and Suicide

There are many risk factors identified by researchers that affect suicidality (e.g., Cassidy et al., 2018; CDC, 2023; Joiner, 2005; Joiner et al., 2009; Van Orden et al., 2023). Suicidality develops differently in individuals with autism compared to non-autistic individuals, and therefore, risk factors may also be different (Cassidy et al., 2018; Pelton et al., 2020). Risk factors have been identified here earlier by categories provided by the CDC (2023). Now, five of the most common areas of risk factors that were identified by research, will be addressed, as well as their connection to suicidality: mental disorders, social isolation, unemployment, family conflict, and physical illness (Van Orden et al., 2010).

Mental Health Disorders

Anxiety and Depression. Mental health disorders can impact quality of life, especially when they co-occur with other disorders, such as autism. Anxiety and depression have been reported by up to 80% of adults with autism, leading to significant suicidality (Dow et al., 2021; Lever & Geurts, 2016; Pelton et al., 2023). Many individuals experience mental illness throughout their lifetime. From a sample of 98 individuals with autism, 63% coped with lifetime anxiety, 55% coped with lifetime depression, 19% coped with suicide attempts, and 12% with recent suicidal ideation (Dow et al., 2021). From a population study in Sweden, 20.1% of adults with autism who participated were diagnosed with an anxiety disorder compared to only 8.7% of the control group (Nimmo-Smith et al. 2020). In addition, it was found that half and full siblings of individuals with autism are also commonly diagnosed with anxiety disorders (Nimmo-Smith et al. 2020).

Mental illness is a major risk factor for suicide attempts for individuals with autism. Females with autism, who are commonly victimized, internalize their feelings more than males

with autism, often leading to anxiety and depression (Greenlee et al., 2020). Kolves et al. (2021) found that 90% of individuals with autism who had attempted or died by suicide had a psychiatric condition. Co-occurring psychiatric disorders are a strong indicator for suicidality in the general population (Auerbach et al., 2019). Depression often increases suicidal ideation and is related to the desire for suicide (Van Orden et al., 2010).

The three major components of the Interpersonal Theory of Suicide have also been shown to be related to mental disorders. Silva et al. (2015) found that thwarted belongingness was related to borderline personality disorder, social anxiety, and mood disorders. In addition, perceived burdensomeness was related to mood and psychotic disorders, and acquired capability was related to psychotic disorders and PTSD (Silva et al., 2015). Mental illness, specifically mood disorders, can contribute negatively to one's quality of life, potentially leading to suicidality (Bayam et al., 2023).

Social Anxiety. Another mental disorder that can impact quality of life is social anxiety. Social anxiety is avoidance or fear of social situations, according to the DSM-V-TR (APA, 2022). Social anxiety can become debilitating for some, due to the symptoms of embarrassment, difficulty speaking, meeting strangers, and self-consciousness (APA, 2022). These symptoms could lead to social isolation, a risk factor for suicidality (Hedley et al., 2018). In addition, individuals experiencing social anxiety may sweat, have heart palpitations, blush, or even tremble to the point that it is a problem with employment, school, and relationships (Den Boer, 2000; Gaziel-Guzman et al., 2022). It has been estimated that 21 to 59% of adults with autism meet the diagnostic criteria for social anxiety (Carpita et al., 2023; Lever & Geurts, 2016; Spain et al., 2018).

Social anxiety disorder must meet specific criteria for a diagnosis. Specific criteria include lasting for longer than six months with the fear and anxiety out of proportion to any real threat or harm (APA, DSM-V-TR, 2022). Individuals who experience social anxiety disorder show signs of anxiety and also may feel rejection, humiliation or embarrassment (APA, DSM-V-TR, 2022). Chronic social anxiety can lead to social isolation, a decrease in relationships and leisure time, with an increased risk of suicidality (APA, DSM-V-TR, 2022). Social isolation could cause one to experience thwarted belongingness due to the decrease in personal connections (Joiner, 2005; Van Orden et al., 2010). The links between adult autism and social anxiety are accurate, and of concern, due to the impact on quality of life, mental health, and suicidality (Carpita et al., 2023; Dell'Osso et al., 2021).

Self-Injury. Self-injurious behavior is considered common in individuals with co-occurring intellectual disability and autism (Steenfeldt-Kristensen et al., 2020). Aggressive behaviors directed toward oneself that have the potential to cause tissue damage, include head banging, skin scratching, hair pulling, and self-biting (Minshawi et al., 2014) as well as behaviors that challenge, such as aggression or destruction are less common in the general population (NICE, 2015). These difficult behaviors can lead to psychiatric hospitalizations (Mandell, 2008), emergency room visits (Giannouchos et al., 2023; Kato et al., 2013), physical interventions (Allen et al., 2009), and generally a lower quality of life for the individual with autism and their family (Baghdadli et al., 2014). Prevalence rates of self-injurious behavior in autism range from 33 to 71%, due to sample sizes, definitions of self-injurious behaviors, the severity of intellectual disability, and participant's age (Baghdadli et al., 2003; Cooper et al., 2009; Gulsrud et al., 2018; Steenfeldt-Kristensen et al., 2020). Interventions for self-injurious

behavior are taught through positive and negative reinforcement with attempts to replace behaviors with appropriate communication (Oliver & Richards, 2015).

Behaviors similar to neurotypical individuals with mental health issues have been found in individuals with autism without intellectual disability (Maddox et al., 2017). Self-harm or non-suicidal self-injury (NSSI) occurs in the general population with behaviors, such as burning oneself, cutting skin, and carving on one's skin (Steenfeldt-Kristensen et al., 2020). It is most commonly distinguished by the lack of repetitious movements seen in the self-injurious behaviors of individuals with autism and intellectual disability (Maddox et al., 2017; Steenfeldt-Kristensen et al., 2020). NSSIs are related to an increased chance of suicidality in autistic adults (Cassidy et al., 2020; Maddox et al., 2017; Moseley et al., 2020a). NSSIs are non-suicidal behavior, but related to suicide risk (Moseley et al., 2022a).

A NSSI intends to create a release for emotion, stress, sadness and/or anxiety that negatively impacts oneself, since many individuals report a sense of relief after harming themselves (APA, DSM-V-TR, 2022). Unfortunately, various and continued NSSIs can lead to suicidality (APA, DSM-V-TR, 2022). Adults with strong autistic traits who were middle-aged and older showed an increase five times higher for the potential for suicidality and self-harm compared to the control group (Stewart et al., 2023). NSSI is being considered as a disorder, according to the DSM-V-TR (APA, 2022) as listed under "conditions for further study" (p. 923). The future diagnosis is not expected to include self-injury that is part of a group, cultural practice, or initiation of any kind.

Using the concept of acquired capability from the Interpersonal Theory of Suicide, fearlessness and pain tolerance from the repetition of habitually injuring oneself (e.g., NSSIs)

could create the desire for death, and therefore the capability for suicide (Matney et al., 2018; Moseley et al., 2022a). However, it has been found that pain tolerance is the least reliable indicator of the movement from suicidal ideation to suicidal attempts (Moseley et al., 2022a; Preece et al., 2021; Shahnaz et al., 2020). Lack of previous suicidal attempts does not imply a lack of potential future suicidal attempts, and all suicidality should be taken seriously (Cassidy et al., 2022). For example, the NSSI behavior of cutting is painful, and could be a lethal method of suicide, if there was a reduction of pain and fear of death (Van Orden et al., 2010). There are many ways to attempt suicide, and there are many NSSI behaviors, but there are no particular methods of NSSI that cause suicidality (Griep & MacKinnon, 2020; Moseley et al., 2022a). Cognitive rigidity or perseverating can influence suicidal thought patterns due to its similarity to habituation (Cassidy et al., 2020; Solomon & Corbit, 1974). Interventions for self-harm and NSSIs are based on cognitive behavioral strategies for positive and negative emotional regulation (Maddox et al., 2017; Steenfeldt-Kristensen et al., 2020).

Social Isolation

Loneliness and Isolation. Loneliness is a risk factor that is consistently related to suicidality in the general population (McClelland et al., 2021). Long periods of loneliness can lead to negative mental and physical issues (Holt-Lunstad et al., 2015). It was once believed that individuals with autism preferred to be alone since it appeared that they had no real interest in socialization with others (Mazurak, 2014). Emotional isolation is the loneliness one feels within a relationship (Elmose, 2020; Perlman & Peplau, 1981). Social isolation is not just loneliness, but can also be grief, estranged relationships, lack of connection, social withdrawal, and imprisonment (Van Orden et al., 2010).

Individuals with autism who experience loneliness and social isolation with limited support can lead to self-destructive behaviors (Shaw et al., 2021; Van Orden et al., 2010). Loneliness and social isolation are believed to be the strongest predictors of suicidality, regardless of age or nationality (Hedley et al., 2018; Joiner & Van Orden, 2008; Van Orden et al., 2010). Recently, a review found increased loneliness in adults with autism, who were also experiencing risk factors, such as anxiety, learned helplessness, depression, and suicidal ideation (Grace et al., 2022). To feel included in a group socially, Williams (2009) states the need threat model shows four areas that need to be present: control over one's social environment, the need to belong with others, the need to have strong self-esteem, and the need to have a meaningful life. Individuals with autism can be strongly impacted by social exclusion and its impact on self-esteem, belonging, control, and meaningfulness (Reich & Pond, 2023). Finally, Elmose (2020) found individuals with autism have the need to be accepted and understood as their reciprocal relationships enhance the sense of belongingness (Van Orden et al., 2010).

Stigma. Stigma comes from the wrong and fearful beliefs of the unknown in our society, which can impact bias, discrimination, mental illness, and social isolation (Rocha Araujo et al., 2023). Recently, Andersen et al. (2022) modified a definition of stigma from Link & Phelan (2001) to include four categories: stereotyping, labeling, linguistic separation, and power symmetry. Internalized stigma occurs when one believes and internalizes the negative attitudes and beliefs about them, often leading to mental illness (Han et al., 2023). Unfortunately, individuals with mental illness often believe these negative labels and portrayals about their mental illness (Rocha Araujo et al., 2023).

Four areas of support were found for individuals with autism to help in managing the negative attributes of stigma: 1) focus on positive, practical support; 2) change society not

autistic people; 3) there is no ‘one size fits all’ approach; and 4) stigma is difficult to manage alone (Han et al., 2023). Knowledge about autism reduces the stigma around it (Gillespie-Lynch et al., 2015; Obeid et al., 2015; Rocha Araujo et al., 2023). When providing training and knowledge to college students about autism, Gillespie-Lynch et al. (2015) found a level of acceptance by some students. This anti-stigma intervention used towards autism found that while participants were “somewhat willing” to make contact with an individual with autism, no one was willing to have a romantic relationship with an individual with autism, and perhaps needed more knowledge training (Gillespie-Lynch et al., 2015). Not surprisingly, family members of individuals with autism had reduced stigma (Gillespie-Lynch et al., 2015). This study was also successfully replicated by Obeid et al. (2015) in Lebanon with some cultural differences in the findings (Rocha Araujo et al., 2023).

Lastly there is a great deal of stigma around suicide (Joiner, 2005). Many people have a difficult time disclosing that they are having suicidal thoughts and/or behaviors (Fulginiti & Frey, 2019; Hom et al., 2017; Love & Morgan, 2021). Individuals with autism commonly experience alexithymia, a condition that makes it difficult to name and describe one’s feelings and emotions, which can cause challenges with mental health and emotion regulation (Riethof et al., 2020). Chaudoir & Fisher (2010) created the Disclosure Processes Model, showing that individuals have goals in wanting to disclose their suicidality. For example, an individual may be looking for support or acceptance, and get a sense of relief from the distress after disclosing their suicidality, but this can vary by individual (Fulginiti & Frey, 2019; Hom et al., 2017; Love & Morgan, 2021). Examples of not wanting to disclose one’s suicidality are involuntary hospitalization, shame, judgment, stigma & fear (Blanchard, 2017; Blanchard & Farber, 2020).

Autism Burnout. Autism burnout affects individuals with autism negatively with issues to their mental health, general well-being, and suicidality (Mantzalas et al., 2022). Exhaustion, social withdrawal, and reduced functioning are signs of autistic burnout (Arnold et al., 2023). Autistic burnout occurs due to the overwhelming weight of the stress of being autistic (Schuck et al., 2022). For example, risk factors such as camouflaging, special interests, sensory stimulation and overload, alexithymia, and managing co-occurring disorders can get to the overwhelming point of burnout (Arnold et al., 2023; Mantzalas et al., 2022). Individuals who experience alexithymia often have atypical interoception, the inability to notice hunger, stress, and pain, which can also lead to autistic burnout (Mantzalas et al., 2021; Shah et al., 2016).

Individuals with autism are often misdiagnosed with bipolar disorder, anxiety and depression when experiencing symptoms of autism burnout (Arnold et al., 2023). When experiencing autism burnout, individuals often feel as if they have lost control as well as the learned skills of self-care, special interests, sensory stimulation, and social communication (Higgins et al., 2021; Mantzalas et al., 2021; Raymaker et al., 2020). Autism burnout can be triggered by stressful life events, such as bullying, unemployment, and discrimination, with risk and symptoms increasing if there is no support, or concerns are ignored or dismissed (Griffiths et al., 2019; Raymaker et al., 2020).

Some factors help alleviate autism burnout. Protective factors include sensory withdrawal and avoidance, stimming to regulate emotions, and if beneficial, special interests (Mantzalas et al., 2021, 2022). More protective factors include a connection to others who have experienced similar stressors as well as social inclusion and positive life changes (Higgins et al., 2021; Mantzalas et al., 2021). Maintaining a sense of belongingness by connecting with people has a positive impact on one's satisfaction with life (Casagrande et al., 2020; Van Orden et al., 2010).

Multiple supportive systems are available including autism communities that exist online through blogs, social media and advocacy programs (Mantzalas et al., 2021; Raymaker et al., 2020).

Late Diagnosis. Individuals who are diagnosed with autism as adults experience various challenges. First, most clinicians request a developmental history from the client, which may or may not be accessible from a parent (Lai & Baron-Cohen, 2015). Next are the multiple assessments to confirm autism, determine possible co-morbidities, and to rule out other disorders, such as psychosis, ADHD, schizophrenia, or obsessive-compulsive disorder (Lai & Baron-Cohen, 2015). False negatives and gender bias in diagnostic testing often leave women with a misdiagnosis or missed diagnosis of autism diagnosis (Beck et al., 2020; Fusar-Poli et al., 2020; Gesi et al., 2021). Unfortunately, men and women with autism who camouflage their autistic behaviors are at a higher risk of mental illness and suicidality, possibly due to the lack of belonging (Cage et al., 2018; Cassidy, Gould et al., 2020). Older adults more commonly experience social isolation, grief, and stigma due to concerns about mental and physical health. Experiencing thwarted belongingness due to social isolation and stigma, and perceived burdensomeness from grief and mental or physical illnesses increases suicidality (Joiner et al., 2009; Van Orden et al., 2010).

Risk factors put older adults at a high risk for suicidality (Joiner et al., 2009). Older age is not a protective factor from suicidal attempts for individuals with autism as it is in the general population (Kolves et al., 2021). There is a group of the population who missed their possible autism diagnosis due to changing DSM criteria, socioeconomic status, assessments, gender bias, camouflaging, or even intellectual development (Atherton et al., 2022; Lai & Baron-Cohen, 2015; McDonald, 2020). These individuals often choose to self-diagnose and are sometimes

referred to as the “lost generation” (McDonald, 2020). In an Australian study the autistic traits and older age predicted a diagnosis of autism at an older age along with a family history of autism, being female, language other than English and lifetime depression (Huang et al., 2021). Adults with autism, who finally receive their diagnosis, feel more comfortable being themselves, not conforming to neurotypical standards, and reducing the camouflaging (Bradley et al., 2021). Thwarted belongingness and perceived burdensomeness feelings may change with a new diagnosis.

Most individuals with autism who receive their diagnosis as an adult report that it is a positive experience (Leedham et al., 2020; Lewis, 2016). This, however, is not to minimize the stress from receiving a new identity, understanding what this new identity means, how others will relate to you now with a new diagnosis, and other changes that may occur (Zener, 2019). In their mixed methods study, Atherton and colleagues (2022) found that participants felt the process of receiving an adult diagnosis needed improvement. Suggestions included therapeutic support for camouflaging, self-esteem, sensory-sensitive environments, managing stereotypes about autism, diagnostic testing results, positives about autism, and how to disclose the new diagnosis (Atherton et al., 2022; Crane et al., 2021; Lai & Baron-Cohen, 2015). Keller et al. (2023) believe that interventions in communication and self-reliance are needed as well as coaching strategies for employment.

Camouflaging. While creating the Camouflaging Autistic Traits Questionnaire (CAT-Q), Hull et al. (2019) created three categories of camouflaging: compensation, masking, and assimilation. Compensation is copying others, and creating different personas from watching others (Cassidy, Gould et al., 2020; Hull et al., 2017). Masking is monitoring one’s own behavior, such as maintaining eye contact and making an intentional effort to show interest in

conversations by using facial expressions (Cassidy, Gould et al., 2020; Hull et al., 2017). Assimilation is forcing oneself to interact socially, similar to pretending or acting. For example, a few participants stated that in conversations or meetings they nod more often, or ask “you” questions to avoid topics about themselves (Cassidy, Gould et al., 2020; Hull et al., 2017). Camouflaging can have an impact on mental health and wellbeing, according to Cage and Troxell-Williams (2019). Camouflaging behaviors are associated with mental illness due to the stress of trying to adapt to situations in daily life (Cremone et al., 2023).

Social camouflaging was brought to the attention of researchers by individuals with autism who were discussing how they attempt to fit in better with others (Cage and Troxell-Williams, 2019; Lai et al., 2017; Hull et al., 2017). In a study of late-diagnosed women with autism, camouflaging caused exhaustion and issues with identity and self-esteem (Bargiela et al., 2016). Similarly, Galvin et al. (2024) found that those who camouflage have lower self-compassion which can impact mental health. Camouflaging is a serious suicidal risk factor for both men and women, and needs to be added to the DSM-V-TR as part of the autism diagnosis (APA, 2022; Suckle, 2020).

Camouflaging is most common in milder types of autism without intellectual disability (e.g., level one), and can create a delay in diagnosis or a misdiagnosis of autism (Cremone et al., 2023). According to a study by Hull et al. (2017), camouflaging created anxiety, stress and exhaustion. Anxiety and social anxiety are a product of camouflaging more than depression (Hull et al., 2021). Camouflaging is a risk factor for suicidality in autistic adults (Cassidy et al., 2018). Cassidy, Gould et al. (2020) and Rodgers et al. (2020) both found connections between thwarted belongingness, suicidality and camouflaging autistic traits. The general lack of acceptance of

autism by society makes camouflaging a risk factor for suicide, and makes suicidality a major concern for individuals with autism (Cassidy, Gould et al., 2020).

Unemployment

A third risk factor for suicidality for individuals with autism is unemployment (Van Orden et al., 2010). The unemployment rate in 2023 in the U.S. for people with a disability was 7.2%, over twice as high compared to people without a disability (at a rate of only 3.5%), according to the Bureau of Labor Statistics (BLS: 2024). Adults with autism often find it challenging to get a job due to unwilling employers who may lack knowledge about the benefits of hiring an individual with autism (Scott et al., 2017). Adults with autism may be reliable, efficient, and trustworthy employees regardless of any possible social communication issues (Solomon, 2020). Individuals with autism who were more successful with their daily living skills were found to be more successful at work (Beenstock et al., 2020). Individuals who were young, male, had fewer autistic traits, and had no co-occurring conditions were more likely to get a job, according to Bury et al. (2024). Some employers, however, may believe that individuals with autism are mentally ill, unfit for the job, and/or dangerous, as sometimes shown in the media (Bury et al., 2021; Solomon, 2020).

Another challenge for an adult with autism may be the work environment. Supported employment programs emerged in the 1980s in the U.S. that assisted individuals with disabilities in training and support in work environments (Gerhardt et al., 2014). Individuals with autism combined with non-disabled workers to create an integrated work environment (Gerhardt et al., 2014). Retail employers and government programs often have programs for individuals with disabilities to assist in learning how to follow instructions and work with others to avoid stressful

situations (Gerhardt et al., 2014; Solomon, 2020). There are vocational rehabilitation services to help support individuals with autism with any modifications or support needed on the job as well as on-the-job training programs and empathetic supervisors (Seagraves, 2021).

There are many reasons people leave their employment: new job, poor working environment, wages and benefits, location, and more. Taylor et al. (2019) found that females more often said they left a job because they chose to stop working compared to males. In Germany, Espeloer et al. (2022) completed a study on the unemployment of individuals with autism and higher education levels, and found that their sample unemployment rate was 25.2%, which was five times higher than the general population rate (5.2%). This study also found the most common reason for termination was interpersonal problems (Espeloer et al., 2022).

Being a member of the workforce may positively affect individuals with autism and their quality of life. About three-fourths of people with a disability in the U.S. are neither unemployed nor employed, which means "not in the work force" (BLS, 2024). Negative perceptions about adults with autism may be the reason employment is so challenging (Solomon, 2020). The sense of friendship, community, and belongingness that can exist in a job helps avoid social isolation (Joiner et al., 2009). Available resources such as support from colleagues, identifying needed accommodations for individuals with autism, and access to employment are all positive suggestions for research (Davies et al., 2024). Unfortunately, if this sense of belonging is lost due to job termination, and creates a sense of burdensomeness, the risk of suicidality may be high, according to the Interpersonal Theory of Suicide (Joiner, 2005; Van Orden et al., 2010).

Family Stress

Conflict. Conflicts can occur anywhere and at any time from different expectations, miscommunication, or misunderstandings. In families, factors such as mental health challenges, illness, behaviors, and finances can cause conflict (Kapp & Brown, 2011; Lindsey & Barry, 2018). Individuals with autism can impact their family in both positive ways, through compassion and empathy as well as negative ways, by experiencing stress and extra responsibilities (Argumedes et al., 2018; Burnham Riosa et al., 2023). Togetherness, strong spousal relationships, and family time were found to promote resilience in families with a child with autism (Kapp & Brown, 2011; Kim et al., 2019). Family resilience, when a family can manage hardship and still prosper, includes spirituality, flexibility, problem-solving, communication, and shared beliefs (Patterson, 2002; Walsh, 2002). Families that include individuals with autism with severe behaviors, for example, may experience more stress than families without children with autism (Argumedes et al., 2018). Parents who do not find resilience from difficult situations may experience more family stress (Patterson, 2002; Walsh, 2002).

Culturally diverse families experience conflict in many areas (Papoudi et al., 2021). For example, Lim et al. (2018) found culturally and linguistically diverse families were both confused and challenged when working with education and health services. There are fewer intervention services for children with autism in the U. S. who are Latinx or African American, and families experience resistance when requesting specialized care (Angell & Solomon, 2017; Pearson & Meadan, 2018). Parents who experience more conflict due to their child's autism, such as lack of medical support and/or severe autism symptoms with co-existing conditions, report a heavier burden on the family (Petrou et al., 2018). Family stress can be due to finances and/or employment concerns (Lynch et al., 2022). Lynch and colleagues (2022) found that

parents of children with asthma were more likely to maintain employment compared to parents of children with autism.

Child Abuse and Victimization. Child abuse and victimization are painful but relevant topics to discuss as part of family stress. Unfortunately, family stress can be taken out on children, and to the extreme as child maltreatment or abuse. Research has shown that individuals with autism have experienced high rates of child abuse, victimization, and bullying (Weiss & Fardella, 2018; Trundle et al., 2022). The pooled prevalence for individuals with autism who have experienced victimization is 44%, according to a meta-analysis by Trundle et al. (2022). The research showed that individuals with autism were affected by interpersonal violence: 47% for bullying, 40% for sexual victimization, 16% for child abuse, 13% for cyberbullying and 84% for multiple forms of victimization in the pooled prevalence (Trundle et al., 2022). Adults with autism, not just children, also experience teasing, bullying, and sexual victimization (Weiss & Fardella, 2018). In an online survey of college students, 70% of individuals with autism stated that from the age of 14 through adulthood they had experienced sexual victimization, compared with 45% for individuals without autism (Brown et al., 2017).

One study was completed on interpersonal violence in individuals with autism with over 100 participants who were found to have normalized violence because it happened so frequently and to so many friends with autism (Gibbs & Pellicano, 2023; Pearson et al., 2022b). These participants had created people-pleasing actions, camouflaging, and survival strategies. They had desensitized themselves to violent and abusive relationships, mostly because confiding in others leads to disbelief and lack of support (Pearson et al., 2022). Lack of support from family and friends can be just as traumatic as a violent event (Gibbs & Pellicano, 2023). Most participants found when attempting to confide in someone about the abuse and violence, there was a lack of

acknowledgment or their information was dismissed (Gibbs & Pellicano, 2023). The inability to manage trauma and negative events through effective psychological care can affect mental health, relationships, self-esteem, and lead to suicidality (Camm-Crosbie et al., 2019).

There are not many studies that have researched adults with autism and their experiences of violence (Gibbs et al., 2022). An international study by Griffiths et al. (2019) found that adults with autism experienced relationship abuse, forced sexual activity, and assault more often than non-autistic adults. Unfortunately, there has been some poor report management by criminal justice professionals (Codina & Pereda, 2021), and therefore there is no data on repeated victimization, stalking behaviors, or convictions (Gibbs et al., 2022). Some research has shown that individuals with autism are more vulnerable socially, perhaps due to misunderstanding of non-verbal signals, social cues, or social communication (Fisher et al., 2013; Hellstrom, 2019; Jawaid et al., 2012). However, other research states that issues with emotion regulation and social communication did not relate to victimization (Weiss & Fardella, 2018), but perhaps is related to discrimination and prejudice (Gibbs & Pellicano, 2023). Personal violence and trauma can increase one's risk of suicidality through pain or provocative experiences (Joiner et al., 2009; Van Orden et al., 2010).

Physical Illness

Diagnosing children with autism for physical illnesses has been a challenge for those who are limited verbally, have sensory sensitivities, and/or have difficulty participating in a medical exam (Bauman, 2010; Forde et al., 2022). Physical issues that affect individuals with autism most commonly are sleep disorders, diabetes, epilepsy, obesity, immune disorders, and gastrointestinal disorders with a median number of 11 conditions per person (Forde et al., 2022;

Jones et al., 2016; Weir et al., 2021). Physical illnesses can prevent individuals from attending school or work, maintaining relationships, and feeling burdensome (Van Orden et al., 2010).

Sleep Disorders. Individuals who experience sleep disorders typically complain about the amount, quality and timing of sleep they are receiving (DSM, APA, 2022). The prevalence in adolescents and young adults of sleep-wake disorder range from 3.3% to 4.6% (Sivertsen et al., 2021). The additional delayed sleep phase in Baker and Richdale's study (2017) shows that the participants were unable to fall asleep or wake up at their regular times. The most common sleep disorders for individuals with autism are parasomnias (e.g., sleepwalking, night terrors), insomnia, and night awakenings (Araujo Nogueira et al., 2023).

Sleep-wake disorders are strongly associated with suicidality. Symptoms of insomnia increase the risk of suicidal ideation, suicidal behavior, and death (DSM-V-TR, APA, 2022). In a study by Rumble et al. (2020), circadian rhythm dysregulation was linked to insomnia, depression, and suicidality. In a study by Baker et al. (2018), individuals with autism were found to qualify for sleep disorders through the International Classification of Sleep Disorders-3rd Edition and the Pittsburgh Sleep Quality Index for circadian rhythm sleep-wake disorder and /or insomnia. In addition to meeting this criterion, it was found for the first time that these sleep disorders were related to unemployment status, a suicidal risk factor, in adults with autism (Baker et al., 2018). Individuals with autism experience anxiety, which is related to sleep disorders, a risk factor, and therefore, concerning for suicidality (Cassidy, Cogger-Ward et al., 2021).

Epilepsy. Epilepsy is a brain condition that causes repeated seizures (CDC, 2022a). There are approximately 3.4 million people with epilepsy, about 1.2% of the population in the

U.S. (CDC, 2023). A meta-analysis completed by Abraham et al. (2019) showed a pooled prevalence for suicide ideation was 23.2% and suicide attempts was 7.4% in people with epilepsy, showing that screening and referrals for suicidality are necessary (Mesraoua et al., 2020). In addition to specific medications and their side effects, changing medications can also affect mood and suicidality (Mesraoua et al., 2020; Mula et al., 2013).

Autism spectrum disorder and epilepsy occur frequently together, often in relation to intellectual disabilities (Lukmanji et al., 2019). Bishop et al. (2022) did a study using data from the Medicaid system, and found 11.1% of autistic adults without intellectual disability had epilepsy compared to 34.6% of autistic adults with intellectual disability. Children with epilepsy were found to show symptoms of autism once seizures began, and the symptoms continued even after the seizures were controlled (Holmes et al., 2021). Using terminology such as "socially interested" and "socially approaching" to describe children with epilepsy, Holmes and colleagues (2021) believe that there are many characteristics of autism that apply to some children with epilepsy.

Having co-occurring conditions is a risk factor for suicidality (Van Orden et al., 2010). The most common co-occurring conditions for individuals with epilepsy are asthma, depression, and heart disease (CDC, 2022a). Having multiple medical conditions can make it difficult to maintain relationships, and one may experience stigma, social isolation, and lose their sense of belonging (Billakota et al., 2020; Van Orden et al., 2010). Unfortunately, 66% of adults with epilepsy have four or more co-occurring conditions (CDC, 2022a). The individual with epilepsy may feel a loss of independence, believe they are a burden to their family, and unable to contribute without a job (Joiner, 2005). After all, 32% of adults with epilepsy are unable to work (Billakota et al., 2020; CDC, 2022a). Lack of employment may be due to the fact that more than

one-third of individuals with epilepsy continue to have seizures, even with treatment (CDC, 2022a). In addition, individuals with epilepsy and co-occurring psychiatric disorders have a three to five times greater risk of suicide compared to the general population (Billakota et al., 2020). Having a physical illness or serious medical condition is a risk factor for suicidality due to the impact illnesses can create on one's sense of belonging and burdensomeness (Van Orden et al., 2010).

Preventative Factors

The Interpersonal Theory of Suicide (ITS) provides the framework for both risk factors and preventative factors of suicide (Hill & Katusic, 2020; Joiner, 2005; Van Orden et al., 2010). Creating social relationships with support and personal connections are positive, preventative factors of suicidality (Griffiths et al., 2019). The sense of belonging that an individual experiencing suicidality feels is the preventative measure (CDC, Joiner, 2005; Van Orden et al., 2010). Creating and maintaining strong relationships with family and peers is another preventative factor from suicide for individuals with autism (CDC, 2022b; Joiner, 2005; Van Orden et al., 2010).

One intervention to help the individual with autism have a sense of purpose is to help others through volunteerism (Hill & Katusic, 2020). Using one's areas of interest to meet and share one's skills (e.g., reading, tutoring, gaming) could help the individual with autism feel purposeful, and reverse the sense of perceived burdensomeness (Hill & Katusic, 2020; Van Orden et al., 2010). Structured social activities can include areas of interest for the individual with autism (e.g., painting, gaming, baseball) to help with informal socialization, such as sharing ideas, listening to others and peer support (Hedley et al, 2017; Hill & Katusic, 2020).

Understanding and accepting one's autism identity is also a protective factor (Cage et al., 2018). Connection to one's identity and community through cultural and/or religious events can build one's sense of belonging and reduce suicidality (CDC, 2022b; Joiner et al., 2009; Van Orden et al., 2010).

Individuals experiencing suicidal ideation can progress through thwarted belongingness and perceived burdensomeness, to acquired capability where they experience suicidal behaviors (Joiner, 2005; Van Orden et al., 2010). Resilience and coping strategies are helpful in avoiding mental health issues and suicidality (Ghanouni & Quirke, 2023). Specific coping strategies include regular social support throughout the day, and understanding one's strengths and weaknesses, which can be addressed through a peer group or therapy (Cage et al., 2018; Hedley et al., 2017; Su & Procyshyn, 2023). Programs that teach individuals how to maintain preventative factors, such as hope and meaning in life, have shown positive results (Heisel et al., 2020; Hernandez & Overholser, 2021). Utilizing social service programs to address difficult situations, such as trauma, anxiety, co-occurring conditions, and suicidality that come from painful and provocative events is a preventative strategy of suicide (Hill & Katusic, 2020; Su & Procyshyn, 2023).

Psychoeducation for Healthcare Professionals

Individuals with autism often end up in emergency care because there are so many barriers that they encounter to get healthcare (Doherty et al., 2021). In a study by Mazurek et al. (2023), individuals with autism shared their lived experiences of issues with the clinic environment, a lack of connection with healthcare professionals, scheduling appointments, transportation issues, and insurance costs. Sensory overload and wait-times can also be anxiety

provoking for individuals with autism (Mazurek et al., 2023). Adolescents transitioning into adulthood may have changes from pediatric to adult care, changes in health services as an adult, and may need specific management or coordination of care (Fulceri et al., 2023).

Training programs for healthcare providers to learn assessments for an autism diagnosis by recognizing camouflaging, lack of reciprocal conversations as well as any discrepancies due to income or race, are non-existent (Curran et al., 2024). Healthcare professionals have shared their difficulties in communicating with individuals with autism which may interfere with patients receiving the best treatment (Hirvikoski et al., 2016; Nicolaidis et al., 2021). When the doctor-patient relationship is strained, both doctor and patient have less interest in spending time together (Zhang et al., 2020). To improve healthcare outcomes for individuals with autism, healthcare professionals need training and education in recognizing and understanding autism (Curran et al., 2024; Doherty et al., 2021; Mazurek et al., 2023).

Summary

Five of the most common risk factors for suicidality in adult autism are: mental disorders, social isolation, unemployment, family conflict, and physical illness, according to Van Orden et al. (2010). These five risk factors are reviewed in detail, including their relationship to suicidality and relationship to the ITS framework components (Joiner, 2005; Newell et al., 2023; Van Orden et al., 2010). The lack of information about the lived experience of the individual with autism who has experienced suicidality is a goal for this study. The prevalence of suicidality in individuals with level one autism is too high. Learning and understanding the lived experience of an individual with autism who has experienced suicidality may help decrease the suicide prevalence, may help with specific prevention measures for neurodiverse individuals in crisis,

and may help healthcare workers with education and training necessary for individuals with autism.

Chapter 3: Research Method

There was a scarcity of information from individuals with autism who have experienced suicidality. This was a problem due to the high prevalence of suicidality amongst individuals with level one autism. Evaluating the information on risk factors of suicidality from adults with level one autism helped to understand the lived experience (Van Orden et al., 2010). Using a qualitative, phenomenological research methodology and design allowed this study to be understood through the lived experiences of those who have had incidents of suicidality, and the various risk factors that have affected them (Creswell, 2009; Mertens, 2020; Neubauer et al., 2019; Van Orden et al., 2010). Purposive sampling provided participants with researched questions, and helped researchers understand the lived experience of suicidality among adults with level one autism (Campbell, 2020). The in-depth interviews with therapists of adults with level one autism and suicidality in the U.S. provided individualized information, awareness, and understanding of how to best support these adults (Brinkmann & Kvale, 2015; Creswell, 2009; Roberts, 2020). Each participant will meet with the interviewer/researcher for a 60-minute recorded interview time, and a maximum of 30 minutes for a follow-up meeting for any other necessary information (Mertens, 2020). Interview protocols provided rich information for analysis through transcription, coding, creating themes, and a final report of findings (Nowell et al., 2017; Roberts, 2020).

Through semi-structured interviews, information was gathered through transcribing the interviews. The transcripts and notes were read and analyzed by the researcher in order to turn the data into codes, themes, and subthemes as well as the use of NVivo (Creswell, 2009; Nowell et al., 2017). Using the Interpersonal Theory of Suicide (ITS) framework added to the understanding of suicidality in adults with autism and how they experience the components of

the ITS theory, specifically thwarted belongingness, perceived burdensomeness, and acquired capability (Joiner, 2005; Joiner et al., 2009; Van Orden et al., 2020). Ethical standards were assured during the course of the study with a focus on the three principles of the Belmont Report: respect for others, beneficence, and justice (Pope & Vasquez, 2017). These principles assure that participants were provided choices (e.g., to participate or not), no harm will be done to participants (e.g., providing accommodations), and fairness among age, gender, race and other categories were attempted to be balanced (Privitera, 2020).

Research Methodology and Design (Nature of the Study)

The research method for this study was qualitative and the research design for this study was phenomenological.

Qualitative research is different from quantitative research in many ways. Qualitative research investigates the meaning of individuals and groups to understand a social or human problem (Creswell, 2009). Qualitative studies consider the individual's perceptions through their behavior which changes depending on the historical, psychological, and cultural perspective (Privitera, 2020). Using a holistic perspective, qualitative research follows two principles: reality changes and behavior is dynamic (Privitera, 2020). In qualitative research, the researcher wants to understand the participant's experiences (reality), not as the participant being an object of study, which is typical in quantitative studies (Privitera, 2020). Data was analyzed by creating themes that the researcher organized from the qualitative data from the participants (e.g., interviews), whereas testing variables and numerical relationships measure the data statistically that occurs in quantitative studies (Creswell, 2009). The best approach for the study of individuals with level one autism who have experienced suicidality was a qualitative approach as it provided meaningful data to understand the lived experiences of suicidality.

Several types of qualitative research designs were considered for this study. Case studies, ethnography, grounded theory, narrative inquiry, and phenomenology are all used for qualitative research studies (Creswell, 2009). Case studies are used for events, individuals, or a small group but the data are specific to a date and time, and therefore not applicable for this study as there was no date and time requirement (Creswell, 2009). An ethnography design was also not applicable for this study since the researcher studies a culture or group, and works within the natural setting to observe and interview in the field (Creswell, 2009). Studying and observing over an extended period is necessary for ethnography, but not for this study (Mertens, 2020). Grounded theory uses significant amounts of data to categorize and group to determine the possibility of a new theory which was not the focus of this study (Creswell, 2009). Narrative inquiry utilizes an individual's life to create a story, often combined with the researcher's life (Creswell, 2009). The narrative method was not applicable since this study does not look at one individual's entire life, but the lived experience at a specific time in some individuals' lives. The researcher did not use her life for this study, since it is necessary to set aside one's own experiences in phenomenology, to better understand the participants and their experiences (Creswell, 2009). Phenomenology describes the experience the individual had by sharing what risk factors and how suicidality was experienced for this study (Neubauer et al., 2019; Teherani et al., 2015). Phenomenology is understanding the individual's point of view, and this study considered how the participant experienced risk factors of suicidality, and how the participant worked to prevent experiencing suicidality in the future (Gubrium & Holstein, 2000; Mertens, 2020).

Population and Sample

Individuals with autism have different experiences of suicidality as well as being at high risk for suicidality, compared to their non-autistic peers (Dow et al., 2021; Jachyra et al., 2022; Newell et al., 2023). The U.S. ranked suicide as the 11th highest cause of death with provisional data from 2022 showing a 3% overall increase from 2021 (Curtin et al., 2023; National Center for Health Statistics, 2023). In addition, the most recent prevalence numbers for children with autism is estimated to be 1 in 36 children by the age of 8-years old are diagnosed, or 2.8% (CDC, 2023). Similarly, the prevalence of adult autism, using 2017 data, is 1 in 45 individuals are diagnosed with autism, or 2.21% of the U.S. population, about 5.4 million people (CDC, 2023; Dietz et al., 2020).

Increasing research for individuals with autism and suicidality has occurred over the last decade that have found various prevalence values. Hedley & Uljarević (2018) found 72% of their participants with autism had suicidal ideation, but Hand et al. (2020) found it in only 4.3% of their participants. Similarly, suicidal attempts have ranged from 0.9% (Kolves et al., 2021) to 36% (Paquette-Smith et al., 2014) in the research. Sadly, completed suicide prevalence ranges from 7.7% (Raja et al., 2011) to 0.4% (Kolves et al., 2021) to 0.17% (Kirby et al., 2019). The population for this study includes therapists of adults with autism who experienced suicidality in the U.S., who wish to share their client's lived experience, and who can assist research in understanding the lack of individualized information about risk factors for suicidality.

The target sample for this study was adults with level one autism who experienced suicidality. The sample for this study was seven clients with level one autism spectrum disorder who have experienced suicidality as Moustakas (1994) supports this sample size for qualitative studies. Inclusion criteria for the study was adults with a level one autism diagnosis who have

experienced suicidality, as noted on the consent form (Appendix A). The goal was to study a range of ages and levels of suicidality, balance of genders, and variety of cultures.

Purposive sampling was used when there were specific criteria present to understand the research problem and questions (Creswell, 2009). Purposive sampling allowed the researcher to focus the research questions on the phenomenon, and to learn about the lived experiences of suicidality for individuals with level one autism (Campbell et al., 2020). The expectation of purposive sampling was to choose participants who can help researchers better understand the phenomenon, such as the lived experience of suicidality among adults with level one autism (Campbell et al., 2020). Snowball sampling, or chain sampling, occurs when the researcher is able to expand the sample by referrals from participants (Mertens, 2020). Snowball sampling may be used when participants tell others about the study (Apprendix D). This may occur through the distribution of a flyer to autism research organizations that give approval for a flyer to be circulated. Adults with level one autism who have experienced suicidality will be recruited by flyers at various autism websites.

Materials or Instrumentation

An interview protocol (Appendix B) was utilized to help support the interview process for this study, which increased the understanding and knowledge of suicidality (Brinkmann & Kvale, 2015; Roberts, 2020). Interviews were semi-structured to make sure necessary content was addressing the research questions (Creswell, 2009; Mertens, 2020). For researchers who are utilizing observations and/or semi-structured interviews, Van Schalkwyk and Dewinter (2020) believe these methods are the best when doing qualitative work, aligning with the problem and purpose statements as well as the research questions.

Interview questions were created by the researcher utilizing multiple strategies. Mertens (2020) suggests using longer questions for sensitive topics, such as suicidality. The interview encouraged participants to think about the experience of suicidality, in order to describe it to the researcher in a personal yet knowledgeable way (Roberts, 2020). Another suggestion was using words that were familiar to the participant, or wording the question which allowed the participant to feel it is acceptable to respond (Mertens, 2020). Interview protocols involved planning and strategy, in order for participants to tell their story freely, provided a structure for the researcher, and even identified issues in the interview questions (Rubin & Rubin, 2012; Yin, 2018).

The interview protocol was a guide for the researcher, and was flexible in order to allow for a variety of types of questions (Roberts, 2020). Knowledge questions, main questions, structuring questions, follow-up questions, probing questions, experience/behavior questions, orienting questions, and even opinions were various types of questions available for an interview protocol (Mertens, 2020; Roberts, 2020; Rubin & Rubin, 2012; Seidman, 2013). Once the paperwork was completed (e.g., informed consent), it was a good idea to assure the participant that there were no "wrong" answers, to show interest by listening, and be respectful (Brinkmann & Kvale, 2015; Roberts, 2020; Rubin & Rubin, 2012). Since this study was using the ITS framework, the interview questions were framed by this theory. To assist the participant in feeling comfortable with the interview, accommodations included taking breaks, providing alternative questions or explanations, and/or rescheduling the interview (Privitera, 2020).

In addition to the interview, notetaking during the interviews was done for noting anything of significance about the session (Mertens, 2020; Seidman, 2013). An observational protocol is suggested by Bogdan and Biklen (1997). A single sheet of paper with two columns: one for descriptive notes (e.g., setting, behaviors) and one for reflective notes (e.g., thoughts,

feelings), with date, time and place included (Bogdan & Biklen, 1997). Lastly, documentation by the researcher regarding possible biases, challenges in communication by the participant, outside interruptions, and any important information was maintained in a journal during the study's duration (Brinkmann & Kvale, 2015; Creswell, 2009; Roberts, 2020; Seidman, 2013).

Study Procedures

After IRB approval, recruitment began by sending out letters and flyers (Appendices C & E). The goal was to interview six to eight individuals with level one autism about suicidality (Moustakas, 1994). The focus is on saturation of content and, therefore, the possibility of allowing more participants to be interviewed may be needed (Peoples, 2021). When participants show their interest, information was provided on the study, including informed consent, basic demographics (e.g., age, gender, race), and an agreed upon time to meet ~~online~~ for an interview (Peoples, 2021). For the pre-arranged time and date of the interview, the researcher provided the participant information ~~a link~~ to the interviewee ~~online (e.g., Zoom).~~ Contact information included a dedicated email address strictly for the participants of the study. Confidentiality will be protected by providing pseudonyms for each participant (Pope & Vasquez, 2007).

Using an interview protocol allowed the researcher to have a framework for open-ended questions as well as maintaining focus on the interview topic (Mertens, 2020). Individuals with level one autism had their lived experiences of suicidality recorded through personal interviews with the researcher. Participants were scheduled for one interview for 60 minutes, and a follow-up interview, not to exceed 30 minutes, for any further questions or concerns approximately two weeks later (Mertens, 2020). Follow-up interviews were to collect any data that was missing, or information that was unclear in a more structured manner than the initial semi-structured interview (Peoples, 2021). The researcher ensured that participants were in a safe place to

discuss the sensitive topic of suicidality. Personal interviews were recorded for transcription and data analysis purposes (Mertens, 2020). Observation notes were not needed during the interview (Bogdan & Biklen, 1992; Mertens, 2020; Seidman, 2013). Results showed the lived experiences of suicidality and its risk factors in autistic adults, and how this led to the high prevalence of suicide in autistic individuals.

At the end of the interview, the researcher made sure the participant felt safe, absent from possible triggers to suicidality, and discussed the scheduling of the follow-up interview. After the interview, the researcher began transcription of the recorded interview, in order to maintain a written copy for the reading and analysis of the interview. The researcher added an entry into the study's journal.

Data Analysis

Data collection began with the interview. Open-ended questioning techniques and observations led to patterns, themes and relationships that built the data for thematic analysis (Creswell, 2009). There are six steps in the thematic analysis presented by Nowell et al. (2017) which incorporates the concepts of trustworthiness. Phase 1 was familiarizing oneself with the data which included keeping good records of all data. Continuous and repetitive reading of the transcribed interview data, noticing themes, and reflecting in a journal were the beginning steps of data analysis (Moustakas, 1994). Phase 2 was generating initial codes from peer debriefings, reflexive journaling, team meetings, and possible triangulation. Triangulation is the process of checking information from other sources for consistency, although outside information is not expected for this study (Mertens, 2020). Triangulation was supported for factual data by Guba and Lincoln (1989) as they prefer member checks for participant information. The NVivo software was utilized to assist with coding.

Phase 3 was searching for themes through triangulation and diagramming. Phase 4 was reviewing themes by looking at raw data, themes and subthemes. Phase 5 was consensus for defining and naming themes, notes and documentation of process, and triangulation. Through the ongoing process of reading of the data, the writing of summaries and descriptions began to evolve as an understanding of the phenomena occuring (Neubauer et al., 2019). During the last phase of creating the final report, checking descriptions of processes, providing context, and honesty of all aspects of the study was crucial. Coding the data by topics, and moving on towards themes was what Nowell et al. (2017) suggest before moving on to writing. Phase 6 involved describing the process of analysis and coding with a description of the audit trail, and defending theoretical, methodological and analytical choices in the study. The thematic analysis presented by Nowell et al. (2017) allowed the identifying, analyzing, and reporting of themes and patterns from the data which were aligned to the ITS framework.

Assumptions

An assumption for this study included the trust that participants share their experiences honestly and candidly. This assumption was supported by the confidentiality of participants and their shared experiences as stated in informed consent. Participants were comfortable speaking to someone they barely know, and able to complete the interview.

Limitations

Limitations for this study included small sample size and lack of generalizability (not done in phenomenology), which was true for all qualitative studies (Peoples, 2021). There were many limitations that arose from the study. For example, lack of specific accommodations for

those who need them (Peoples, 2021). As mentioned earlier in *Study Procedures*, accommodations will be made during the interview for any person who feels that it is needed.

Delimitations

Delimitations for this study included limiting the sample to adults and a smaller sample size. Although Moustakas (1994) suggests the smaller sample size for qualitative studies, it was crucial to speak to enough participants to be able to address the problem and purpose statements and the research questions in depth for saturation (Peoples, 2021).

A second delimitation was the accommodations put into place for the participants (e.g., PowerPoint with interview questions on them; breaks). It is important that the participant has accommodations for understanding the interview questions. By creating a PowerPoint that has questions on each slide for the participant to see, read, and/or refer to helps the participant to feel like an active participant.

Another delimitation is the 60-minute interview timeframe. This parameter for the interview sessions will create focus and direction. However, the interview may not be completed due to the participant's need for more time, breaks, or the need to reschedule.

Lastly, the choice of the Interpersonal Theory of Suicide (ITS: Joiner, 2005), was a delimitation. This framework is thorough and complete, in addition to being the beginning of at least two more ideation-to-action suicide frameworks: Three Step Theory of Suicide (3ST: Klonsky & May, 2015) and the Integrated Motivational-Volitional Model (IMV: O'Connor (2011/2018). The top five risk factors presented by Van Orden et al. (2010) show that individuals with autism are supported by the ITS as delineated in this literature review. There was not a specific framework for individuals with autism who experience suicidality, and the research supports the ITS for both individuals with autism and suicidality (Cassidy et al., 2020; Cremone

et al., 2023; Joiner, 2005; Van Orden et al., 2010). The experiences of the clients provide insight into risk factors of suicidality that helped to highlight the importance of providing support to individuals with autism (Newell et al., 2023; Van Orden et al., 2010).

Ethical Assurances

This study received approval from the National University's Institutional Review Board (IRB) prior to data collection.

The Belmont Report, published in 1979 as a guide for ethical behavior in psychology, recommends three principles for research with human beings: respect for persons, beneficence, and justice (Pope & Vasquez, 2007; Privitera, 2020). Showing respect for participants allowed them to make their own informed decisions about the study from information provided in the informed consent document as well as honest responses to any questions they may have (Mertens, 2020). To show respect for participants, the interview questions allowed participants to feel comfortable, and not offended or under any duress (Privitera, 2020). Participants were not coerced into answering any questions, and did not skip any questions (Pope & Vasquez, 2007).

Beneficence is the principle for assuring unnecessary harm, risk, or wrongdoing are not occurring during the study (Mertens, 2020; Privitera, 2020). This study involved two special populations: adults with level one autism and individuals who have experienced suicidality. Special populations include individuals with disabilities, such as autism spectrum disorder (Mertens, 2020). When recruiting for the study, participants were not pressured to participate for any reason (Pope & Vasquez, 2007). Time was given for each participant to understand the informed consent form (Mertens, 2020; Pope & Vasquez, 2007). To avoid harm, the researcher gave regular check-ins with the participant during the interview to make sure they were comfortable, and not under duress. Checking-in allows the researcher to take time and show

respect regarding the seriousness of the topic, observe any change in symptom severity (e.g., stimming, hair twisting/pulling), and evaluate the level of discomfort of the participant (Mertens, 2020). The researcher will also have resources available, including the contact numbers for the suicide hotline (988), be available to assist in contacting someone close for them to speak to, and/or stay with them online for as long as needed until someone is available. Confidentiality was protected through a secure phone line and recording device as well as pseudonyms were used to protect identity (Privitera, 2020). Data was secured at all times while in the possession of the researcher (Creswell, 2009; Pope & Vasquez, 2007).

Justice was adhered to by recruiting adults with level one autism with various experiences of suicidality as well as individuals from various cultures, different age groups, socioeconomic backgrounds, and education levels (Privitera, 2020). Inclusion criteria for clients was any American adult who has a level one autism diagnosis, and experienced suicidality. Exclusion criteria was any client below the age of 18, and anyone who needed a guardian to sign permission for them to participate. It is important to note that special populations need to be involved, yet protected, in research for the benefits and knowledge they bring to a study, and not denied access due to their vulnerabilities (Welch et al., 2015).

The role of the qualitative researcher is to listen and understand the lived experiences of the clients, in this study through personal interviews. Helping the participant feel comfortable allowed them to tell their client's story, which in turn helps others to gain insight about their thoughts, feelings, and experiences (Sutton & Austin, 2015). Topics like suicidality are difficult to talk about and share, which means the researcher was sensitive to these challenges (Mertens, 2020; Sutton & Austin, 2015). One strategy to avoid bias was to discuss topics openly. As an older White woman and study researcher, my experiences with individuals with autism are

varied. As an educator for over three decades, there were many young people that I worked with who were at various points on the autism spectrum. In addition, my youngest adult son is probably a level one individual with autism, although he remains undiagnosed by his own choice. My experiences with suicide are more personal. My late mother was bipolar, and her depressive cycles led her to self-injuries, lots of suicidal ideation, and a few suicidal attempts, although her passing was unrelated to suicide. Fortunately, none of my mother's four daughters experience suicidality, nor any of my own children, for which I am very grateful.

Summary

Choosing the appropriate research method was not a simple task. A qualitative study was used to understand individual experiences of those who have encountered a human or social issue, and by using an individual's behavior to understand their experiences (Creswell, 2009; Privitera, 2020). Phenomenology considered the lived experience of an individual's event or issue, in order to understand the individual and their experience better (Creswell, 2009). This study looked at the experience of suicidality and the risk factors that were present for the individual with level one autism, in addition to learning the preventative measures the individuals were using now and for the future (Neubauer et al., 2019). The purpose of this qualitative, phenomenological study was to interpret the value of the information about risk factors of suicidality, and how this was affecting the prevalence of suicide amongst individuals with level one autism.

The target sample and population for this study was six to eight adults who had experienced suicidality and had a diagnosis of level one autism (Moustakas, 1994). The research questions for this study guided the researcher towards the phenomenon and the lived experiences of the individual with level one autism (Campbell et al., 2020). Purposive sampling allowed the

researcher to find participants who fit specific criteria (e.g., level one autism, adult, suicidality experience) which led to a better understanding of the phenomenon (Campbell et al., 2020).

Semi-structured interviews are the best for qualitative studies, according to Van Schalkwyk and Dewinter (2020). Interview protocols were created as a guide for the interviewer, included a variety of questioning strategies, and remained flexible enough for the participant to share the lived experience (Mertens, 2020; Rubin & Rubin, 2012; Yin, 2018). An interview protocol was created by the researcher to assure that interview questions encourage participants to provide thoughtful and meaningful responses (Roberts, 2020). Follow-up interviews were conducted in order to add any missed or confusing information (Peoples, 2021). An observational protocol suggested by Bogdan and Biklen (1992) will also be utilized during the online interviews to note non-verbal communication and behavior of the participant as well as any issues, feelings, biases or challenges during the interview process. Lastly, the researcher maintained a journal during the study for any concerns, for a kept a reliable audit trail, and assistance in thematic analysis (Brinkmann & Kvale, 2015; Creswell, 2009; Roberts, 2020; Seidman, 2013).

Ethics were assured for all participants in the research study. The Belmont Report (1979) provides three principles which will be followed in this study: respect for all persons, beneficence, and justice (Pope & Vasquez, 2007; Privitera, 2020). Respect for all persons includes making one's own informed decisions, assisting the participant in understanding the purpose of the study (e.g., informed consent), and assuring the participant's comfort during the interview, especially due to the sensitive topic of suicide (Mertens, 2020; Pope & Vasquez, 2007). Beneficence was honored as there was no harm to the participant including no pressure to participate or answer questions (Pope & Vasquez, 2007). The researcher checked in regularly

during the interview process to ensure the participant was not experiencing stress as well as monitor observations for any changes in behavior (Bogdan & Biklen, 1992; Mertens, 2020). Confidentiality was also be protected through pseudonyms and onlsecurity (Creswell, 2009; Privitera, 2020).

Thematic analysis was done through the iterative process that Nowell et al. (2017) suggests in six phases. This process allowed repetition through ongoing readings of the data, slow progression towards codes and themes as well as suggestions for the final narrative (Nowell et al., 2017). The final report provided the findings of the descriptions and context of the lived experiences of the participants as well as clarity about the data and themes created (Mertens, 2020; Nowell et al., 2017).

Chapter 4: Findings

The problem addressed in this study was the lack of information about suicidality among adults with level one autism. Suicidality often looks different for individuals who are autistic compared to those who are non-autistic, which explained the importance of studying individualized experiences. The purpose of this study was to learn about the factors that lead to the high prevalence of suicidality using a phenomenological design. The phenomenological methodology was best for understanding the meaning of one's lived experiences (Peoples, 2021).

The first section of this chapter begins with the trustworthiness of the data and how it was determined. The four elements of trustworthiness are discussed individually to demonstrate the integrity of this study. The second section, the reporting of the results, was based on the three research questions including the demographics of the study. The research questions show how the questions are related to the results. The third section is the evaluation which uses both research and theoretical frameworks to discuss the research questions. This chapter will close with a summary of the key points.

Trustworthiness of the Data

There are four concepts of trustworthiness according to Yardley (2017): credibility, dependability, confirmability, and transferability.

Credibility for this study was accomplished through data triangulation. Using multiple sources to study the same phenomenon increases the credibility of the findings (Carter et al., 2014). Interviewing individuals with level one autism who have experienced suicidality but comparing people of different places, different age groups, different genders, and at different times triangulates the data in order to confirm that results are credible. For example, it was

shocking to find that all clients had experienced significant levels of trauma in their life. This one finding shows that this type of experience can cross each individual's life, and bring credibility to the depth and seriousness of suicidality in individuals with autism. Gathering data from a multitude of individuals, the researcher was able to see themes and patterns in the data, and therefore determine a more accurate understanding of the findings.

Connelly (2016) also suggests three ways to achieve credibility. First, standard procedures were followed, such as establishing research questions, conducting interviews, creating codes and themes from the transcripts to find patterns (data) for analysis, and reporting findings and results (Creswell, 2009). The second way was through the interviews with participants. The interview sessions lasted between 22 and 56 minutes which showed the ability for prolonged engagement with participants allowing time for the confidence to build between the interviewer and the participant. And lastly, reflexive journaling occurred throughout this study to question general categories of accuracy and appropriateness as well as more specific categories such as the ability to receive and retain participants.

Transferability showed usefulness and relevance of the findings (Creswell, 2009). Transferability referred to the description of sampling elements such as geographical location and characteristics of clients (Creswell, 2009). Geographically, clients were very balanced: two were from Wisconsin, two from Oregon, two from California, and one from Washington (state). (See Table 1, States Contacted During Recruitment). All participants were interviewed by phone after receiving the signed consent form. Participants were therapists who came from four states in the U. S. found through the *Psychology Today* database. This was an adjustment from the original recruitment plan of speaking to adults with level one autism. All appointments were made at the participant's convenience, and all phone calls were recorded. Participants confirmed

that their clients had been diagnosed with level one autism and were over the age of 18. Pseudonyms were used for all clients, and there was no mention of actual names of clients. Two of the clients were diagnosed in middle school, two in their twenties, and three in their thirties. There were four of seven clients (57.1%) who were non-binary and three of seven (42.9%) who had been diagnosed with ADHD as well as autism. (For more information see Table 2, Client Demographics). The experiences of suicidality and the challenges with relationships were common with the clients in this study. Transferability was achieved in this study when the findings were similar among clients who had experienced trauma from abuse, challenges with relationships, and suicidality.

Dependability referred to the stability of the data over time (Connelly, 2016). A complete and thorough description of the methodology and design led one to a dependable duplicate of this study. The method for this study was qualitative and the design was phenomenological. Thematic analysis was used to explore coding, themes and patterns, in order to understand the meaning of the clients' experiences. Researchers chose qualitative methods to ask more in-depth questions, to write narratives, and to learn about other people's experiences (Creswell, 2009). Phenomenological research focused on the lived experiences from a participant's point of view (Mertens, 2020). Thematic analysis has six steps which incorporates trustworthiness, according to Nowell et al. (2017).

Data was gathered through semi-structured interviews with each participant by telephone and audio recorder, and conducted by the researcher. Pre-screening was not necessary due to the IRB permission. The eligibility criteria were present on the consent form. Interview questions were provided from Appendix B1 and written consent was received by all participants.

Confirmability managed the data and interpretations of the findings to be assured that there was no researcher bias, and that the study and data are in fact, based on truth (Korstjens & Moser, 2017). When working through the six steps of thematic analysis, repetitive and continuous reading and familiarizing oneself with the transcripts in Phase 1 was just as important as reflections in the reflexive journal (Moustakas, 1994). Phase 2 allowed the researcher to initiate codes through data triangulation, transcripts and research (Mertens, 2020).

Codes were based on actual words that the participant's used to talk about the lived experience of their clients. Themes were the focus for the next three phases of analysis. Phase 3 was searching for themes, and Phase 4 was reviewing and approving themes. The themes were first created by the researcher using a-priori coding technique or a pre-defined method. The key words and ideas from the interview were used to create themes. The researcher took the words and ideas from the transcripts (codes), listing them under the themes. Unfortunately, this created confusion in understanding the data clearly, and it was apparent that researcher bias had occurred. This personal awareness occurred due to the journal, and was crucial during analysis, even if when the researcher's values are insignificant to the study (Bynum & Varpio, 2018; Mertens, 2020). In-vivo coding techniques were then used for exact wording whereas interpretive coding was used for motivations and emotions. NVivo 14 was helpful in organizing the repeating codes. The reflexive journal allowed the transparency for researcher bias to be recognized and addressed efficiently.

Content Warning

This chapter contains excerpts of descriptions of violence, abuse, and suicidal behaviors. People who have experienced these themes may find some of this content challenging. Similarly, those who have never been exposed to this type of content may find the content disturbing.

Results

There were many different types of risk factors the led to the likelihood of suicidality. However, no researchers have found why these risk factors were different for individuals with autism (Dow et al., 2021; Nyrenius et al., 2023; Pelton et al., 2023). Utilizing the concepts of the Interpersonal Theory of Suicide (ITS) framework gave additional understanding to how suicidality develops as well as the similarities and differences between those with autism and those without autism (Joiner, 2009). Learning about the lived experience of suicidality from an adult with autism can increase the knowledge and recognition for best practices and to reduce the prevalence of suicide (Stewart et al., 2023). Building awareness about the tragedy of suicide among individuals with autism is needed.

A total of five individual therapist-participants in this study shared the lived experience of suicidality among seven adults with autism. Two therapists each shared two clients' experiences. For example, clients Bob and Belle had the same therapist, and Robin and Kelly had the same therapist. Therapists were called all over the United States during recruitment, and had clients who met the eligibility requirements for the study. (See Table 1., States Contacted during Recruitment).

Table 1.

States Contacted during Recruitment

States Contacted

Arkansas, Arizona, California (2), Colorado, Connecticut, Georgia, Idaho, Illinois, Maryland,
Minnesota, Missouri, Nevada, New Jersey, New York, Oregon (2), Pennsylvania, South
Carolina, Tennessee, Texas, Utah, Washington (1), Wisconsin (2).

Note: Parentheses indicate number of therapists interviewed by state.

The clients ranged in age from 22-45 years of age with a mean age of 32.29 years. (See Table 2, Client Demographics). Of the seven clients, four were White/Caucasian, one Hispanic, one Mixed Race (Hispanic and White), and one was unknown. For gender, two were male, four were non-binary, and one was a transwoman. Clients varied in age of their autism diagnosis. Two clients were approximately 11/12 years old, two clients were in their 20s (23 & 28), and three clients were in their 30s (31, 32, 33) with a mean average of 24.4 years old. In addition, all clients had co-morbid disabilities with their autism diagnosis. Three clients had been diagnosed with ADHD and /or Substance Abuse. Two clients had Arthritis. And lastly, at least one client had been diagnosed with one of the following: Bipolar Disorder, Fibromyalgia, Anisomilia, Hypermobility, Neuropathy and /or sleep disorders due to stress.

Table 2.

Client Demographics

Client Name	AGE @ Interview	GENDER	RACE	DISABILITIES	AGE @ Diagnosis	STATE LIVING IN
BAILEY	34	Transwoman	Unknown	ASD. ADHD.	31	WA
BELLE	29	Nonbinary	White	ASD. Arthritis.	27-29	WI
BOB	37	Nonbinary (Female @ birth)	White	ASD. ADHD. Arthritis. Anisomilia (Uneven leg length).	33	WI
JOSE	45	Male	Hispanic	ASD.	12	CA

KELLY	34	Nonbinary	White	ASD. ADHD. Neuropathy.	32	OR
ROBIN	25	Nonbinary	White & Hispanic	ASD. Hypermobility. Fibromyalgia.	23	OR
SHANE	22	Male	Unknown	ASD. Bipolar.	11-12	CA

RQ1: What are the experiences for the individuals with autism when the risk factors for suicidality are present?

Four main risk factors, or themes, were identified that reflect the experiences for individuals with autism when suicidality is present. These themes were consistent across the research: mental health, unhealthy relationships, the autistic individual, and major life changes. First, mental health considered anxiety, shame and trauma experiences that individuals with autism undergo to be risk factors for suicidality. Second, the relationships that the clients had with family, peers, and social groups was present and complex. Unhealthy relationships were clear which increased stress and isolation, especially among individuals with autism who often struggle with characteristics such as communication. Third, some traits specific to individuals with autism, including rigidity, sensory sensitivities, masking behaviors, and experiences of late diagnosis, added additional distress which affect mental health and lead to mental illness. Finally, life transitions such as changes in schooling, employment, family dynamics, or living environments can be particularly overwhelming. While life changes affect everyone, they may pose greater risk for individuals with autism, who may struggle with unpredictability and adjustment, which in turn increases one's vulnerability to suicidality.

Note: All client names are pseudonyms. There was no mention of actual names of clients or persons related to clients to the interviewer at any time.

Mental Health

Challenges in mental health are the components that increase the possibility of having poor mental health or mental distress (CDC, 2025). Participants shared their client's stories of anxiety, shame, and most significantly, trauma. Mental illness is a group of experiences, as seen in these excerpts, that is often unaddressed. Anxiety was a common expression of stress and turmoil that was occurring for these individuals, often leading to shame, stigma, and trauma.

Anxiety

Anxiety can become overwhelming and devastating. The impact can fluctuate depending on triggers and stress. Recurring episodes of anxiety can be difficult to manage. Shane lived with anxiety on a regular basis that came from threats of eviction from his father. His dad believed he needed to have a job, and if Shane did not get one, he needed to get out.

> *Shane: His father thought he could do more which is very common with autistic people especially males. Their fathers think they can do more than they can actually do. In this case he could not retain a job. … So, Father would threaten to throw him out. … His father could really trigger him into suicidal ideation.*

Kelly dealt off and on with anxiety that was very overwhelming and difficult to manage.

> *Kelly: They would be fine, completely fine. They would take care of themselves, and then I could see that they weren't, and they could go from zero to 100 very quick. …[W]e had a session… where they were completely fine '…everything's good. I don't even know what to talk about' … Then said, 'Well, this happened…' and they went really quick into 'I want to kill myself'.*

Many people experience mental illness at some point in their lives. Treatment and support are necessary for mental health disorders due to their impact on one's quality of life. Feeling overwhelmed from anxiety as both Shane and Kelly experienced can become intolerable, particularly when co-occurring with disorders and/or neurodiversity like autism.

Shame

Shame is the experience of feeling worthless, inadequate, and/or embarrassment by an event. Shame can also be created from stigma, which are beliefs about discrimination or even dishonesty. Shame and stigma can be internalized, creating negative thoughts and behaviors, and contribute to mental illness (Han et al., 2023). For individuals with autism, who are often recognized by their differences, the feelings of embarrassment, hopelessness and shame can lead to depression, anxiety, and other psychological issues (Riebel et al., 2025).

> *Jose: They had been staying with family …This is when the suicidal ideation became really strong for him. He felt that being alone, away from his family would be best since he felt like such a burden. He would go stay at a shelter.*
>
> *Bailey: [They] notified her emergency contact which were her parents who came up to get her and take care of her. Unfortunately, they got into her dorm room and saw the women's clothing. She's at the hospital, really out of it, instead of being supportive, the parents were like 'Well, we are worried about you, but what the hell? Why do you have women's clothing in your closet? Bras and panties? High heels? What's going on?' So, she shuts that part of herself down even further.*

Jose and Bailey's experiences show how distressing shame can be. After losing his job and home, Jose felt unable to support his family and struggled with the belief that he was failing

them. He incorrectly felt unsupported by his family since he could not really pay his own way. Bailey felt unable to live up to the expectations of her parents, which intensified her hopelessness and inadequacy. Dr. Kade Sharp explained, “I think when your brain and your body don’t work the way that society standards dictate that they should work, it becomes very difficult to protect yourself from the shame or criticism or the I’m-not-good-enough in some way which can lead you to those thoughts”.

Abuse and Trauma

Several of the clients had multiple levels of abuse and trauma in their lifetime. The extent of the ill-treatment varied between clients. Five of the seven clients (71.4%) were abused in various ways such as physical, sexual and /or emotional behaviors. The long-term effects of this abuse damages one’s mental health. Robin was abused by both her parents. However, the abuse from her mother caused many more triggers for suicidality, at least until her father passed away.

> *Robin: Their father was physically and emotionally abusive. Their mother was mentally, verbally, emotionally, [and] financially. It seemed like every interaction with their mom, which was daily when they were living together, was triggering. With their father, … interacting with him was not an automatic trigger for suicidality but his death was really, really triggering.*

Parental abuse is horrible at any time or place. The confusion, pain, trauma, and destruction it causes is devastating. By far the worst childhood trauma of all the clients is Bob. The multiple traumas and abuse they endured as a child was seen later as difficulty with emotional regulation and interpersonal connections as well as multiple risk factors for suicide.

Bob: [They were] assigned female at birth. … Their mother had cancer and they moved to [receive] treatment for her. … At some point they remember snuggling up with their mom in the hospital bed [at 7 years old]. Dad leaves to get snacks, and when he returns, Mom has died…Dad's first reaction was blame. … 'Did you do this to her?'

… [They] looked a lot like the mom so the dad started raping [them]. When they were 15, they came out as a lesbian, and by that time there was a stepmom in the house who did not know about the sexual abuse… The parents kicked them out, and they were homeless at 15. … lived on the streets, did sex work, was an escort, all these things. No stability, no real relationships…. Addicted to drugs. Their brother was addicted to drugs.

Abuse and trauma occurred in every client's story highlighting how these individuals' showed strength and resilience above all else. Unfortunately, the unresolved trauma from continuous abuse can lead to mental illness and have a long-lasting impact and influence suicidality. The trauma and abuse these clients endured took years of therapy to help them recover. It is unfortunate that these individuals have had to experience this, and often lost their purpose and reason for living. As children, these individuals were treated horribly, leading to patterns that continued into adulthood creating relationships that lacked connection and positive support.

Unhealthy Relationships

Social communication is a main factor in the diagnosis of autism, according to the DSM-V-TR (APA, 2022), meaning some individuals grapple with communication and possibly relationships. People have relationships in many areas of life including personal and professional, and can even experience significant relationship trauma. Personal relationships

include those closest to us - family, friends and social groups. Issues in relationships often occur when the communication in the relationship is not going well, perhaps even just a disagreement or a misunderstanding. If communication becomes strained, there may be conflict that can affect trust. Repeated conflict can lead to an unhealthy relationship which can cause anxiety, dependency, and even trauma.

Family

Family dynamics do play a significant role in how we manage stress, express our emotions and build relationships with others. Family communication can be unique since it often includes individual roles, emotional connections, and levels of authority. Family dynamics can be broken or even toxic. When unhealthy communication exists, creating new responses, seeking support, and reducing contact are often the beginning, but challenging, path toward change. Kelly dealt with abuse on a regular basis with her mother. They were so afraid of their mother that they believed that the mom could harm them even though she was not physically present.

> *Kelly: [T]hey have a very complex relationship with their mother. Their mother was the one regularly abusing them growing up with mental, emotional and verbal abuse. They were trying to make the decision as to whether or not to continue to speak to their mother. They were really worried if they were to end that relationship then their mother would physically come find them and make them stay in that relationship. So, they were terrified of that happening.*
>
> *Belle: Mom is a trigger. Mom seems to be just emotionally immature, unequipped, unintelligent. I'm sure that my client has taken care of their mom emotionally a lot*

growing up. Just developed a lot of co-dependency. … They don't really open up about things.

Professional relationship

Professional relationships occur at work or school, and are shown by less personal information shared between individuals than what would be shared with family. These relationships can grow from working together or on specific projects or having common interests. Bailey continued to work in a male-dominated profession without directly informing them about the gender transition. This created an unhealthy relationship as she endured some bullying, just as Shane did.

Bailey: They used to make a lot of queer jokes, pick on each other, rib on each other, drink together after meetings. When she started painting her fingernails, they started saying, 'Oh, you painting your nails this time. You going to use the ladies' room too? Hahaha.'

Shane: In this case, he could not retain a job… He was bullied pretty bad. He did have a job at Taco Bell, and someone told him to hurry up or work faster. He thought that was bullying and refused to go back.

Relationship trauma

Individuals who experience childhood trauma may experience serious mental health issues and problems with relationships. According to Bowen's family systems theory, how one's original family experiences intimacy, behavior and interactions impacts their future relationships (Kerr and Bowen, 1988). Robin had two parents who abused them, but when their father died it

triggered suicidal ideation regularly. Unhealthy communication and verbal abuse with their mother continued, and now there were also challenges with their partner.

Bob's trauma began when they were young and continued into their 20s. There were times when Bob did attempt to have positive relationships in their life. In spite of the trauma Bob had been through with sexual abuse, homelessness and abandonment, they found a relationship with Riley, "They were best friends but they were partners too". Unfortunately, this relationship ended with more trauma for Bob when "*Riley broke up with them, and the next day committed suicide".*

> *Robin: There were negative interactions with the partners … that triggered suicidal ideation, definitely. [It] seemed like they didn't understand each other sometimes, and that would lead to fights. There was a lot of issue around not being understood because of the neurodivergence, so there was a lot of arguments.*

Relationship trauma occurred for Belle with multiple break-ups and infidelities. In addition to the unsuccessful relationships, Belle also had a poor relationship with their mother. The inability of the mom to support Belle was evident, even though Belle continued to be hopeful that their mom would help.

> *Belle: Their partner cheated on them…. [and] recently broke up with them. They gave the partner a second chance but broke up a year later. This is the third partner that has broken up with them… [From Mom] it was just a lack of support all around. Like pretending there is support but there isn't. It was partial support which wasn't helpful. That's exactly how they felt. Not helpful.*

Unhealthy communication can look like the silent treatment, yelling, shame, or abuse, like Robin's mom. Children who have learned that these types of communication such as ignoring one's feelings, may feel incapable of speaking up, like Belle, as they mature. As an adult, anxiety, low self-worth, or mistrusting others may challenge new relationships. Challenges in relationships are risk factors that can lead to suicidality in individuals with autism.

The Autistic Individual

People with autism are unique individuals. There are traits that some individuals share, but there are just as many traits that individuals do not share. A popular quote by Dr. Stephen Shore states, "When you meet one person with Autism, you've met one person with Autism". This quote illuminates the fact that each individual with autism is different and complex, and should not be put into a group or category, regardless of common traits in their diagnoses. A few common traits that have been found linked with suicidality is the rigidity of actions, sensory sensitivities, camouflaging, and late diagnosis.

Rigidity

Having intense focus in one area, literal interpretations in language, and inflexibility in routines are a few examples that people with rigidity experience (Cassidy, 2020). Some individuals may adhere to a strict personal behavior that may include eating at a specific time, or completing tasks in a specific way. The need for routine is often considered to be comforting to an individual with autism. Separately, an individual with obsessive-compulsive disorder often feels the need (the compulsion) to complete a task such as handwashing, and is not necessarily satisfied by the behavior (DSM-V-TR, 2022).

Jose was comfortable with his routines and structure in his life. Unfortunately, he became very overwhelmed after he lost his job and felt his wife was unhappy with him. He had never had a problem finding work before. He did not understand it. He didn't have a schedule, or a plan that was working. No money, and now no place to live.

> *Jose: It was just one thing after another for him. … He believed his wife was unhappy because of his inability to find a job. … he felt like his life was falling apart … and had no idea how to manage it.*
>
> *Belle: I think those co-dependencies of taking care of someone else before myself has kind of been the red line to come back from suicidality. I mean 'I need to take care of the animals.' 'I can't hurt my partner.' 'I have to show up to work and take care of my patients.'…[and] they feel really burned out.*

The need to complete things and take care of someone when they needed it was a powerful feeling for Belle. For Belle, the rigidity originated from having to take care of herself without a parent being present. However, the need to have the rigidity in their lives for both Jose and Belle were to create a sense of security. Rigidity can be intrusive and difficult to manage when change is occurring. Rigidity does not make one compulsive nor does wanting to keep a schedule. However, individuals with autism often experience rigidity in language and thinking making some of their social interactions awkward.

Sensory Sensitivities

Sensory sensitivities are not uncommon with individuals with autism. These are brain processes that occur more or less intensely through the five senses (Hannant et al., 2016). For example, noises may feel uncomfortably loud in which the individual may need to wear

headphones to block noises. Another example is a label in a shirt may feel like sandpaper against the skin.

> *Kelly: We were talking about it in therapy. They had decided to block their mother. … They got a rash due to a medication. But the rash really increased their sensory sensitivities. They became so overwhelmed with anxiety … that they were saying, 'I just need to end it'. Then they tried to take their medication and overdose on it. It was very much trauma and autism sensory stimulation overload.*

Shane would often get anxious about certain family activities. He had some sensory sensitivities, especially with loud noises and bright lights. Although it certainly was due to past trauma, loud noises and crowds often made him feel threatened and out of control.

> *Shane: He would be anxious about it. He really didn't like loud noises. And that particular time he was seeing a cousin's basketball game, sitting in a gym. Well, you know how a gym can be with all the noise and how it echoes.*

Leaving a situation that makes you uncomfortable is always a good decision, as Shane learned before a full meltdown. Sensory sensitivities are also extremely challenging in emergency situations if an individual with autism needs to be touched or examined by a medical professional. Sensory sensitivities can have an impact on school or work due to possible triggers, if grounding techniques and tools have not been adopted.

Camouflaging

Camouflaging behaviors can be observed as compensating, assimilating or masking behaviors, according to Hull et al. (2020) which may include copying, pretending or acting, and showing intentional interest, respectively. Camouflaging behaviors, commonly called masking,

are common for individuals with autism. Bailey always felt "different" but thought it was just because she was adopted. She did not realize she might not be cisgender until she was college age.

> *Bailey: What we now know is masking [is] an autistic trait. She was trying so hard to be like the other men… even though she clearly wasn't. … I'm sure she met a lot of autistic people in the programs. But they hide that… and there's some shame around that and those traits … If you want to fit in, you need to hide your traits too.*
>
> *Belle: I can see it though where maybe they felt they didn't fit in … They don't feel like they function the way they are supposed to function… [If] they have the concept of 'If I am supposed function in the world, then I need to be like that, but I'm not'.*

Bailey's need to feel more neurotypical may have caused more masking behaviors, and added to the feelings of being "different". Belle had a number of emotional challenges occurring with their suicidality being constant, their mother as a trigger and relationship trauma which made them feel as if "pretending" everything was okay was easier.

Late Diagnosis

Each person with autism learns to how to manage their autism the way that suits them best, individually. Another finding for three specific clients was their age at diagnosis: Bailey and Kelly both had a late diagnosis, age 31 and 32, respectively. Jose, although he had a diagnosis young, he never learned anything about his diagnosis. Individuals who have an early diagnosis of autism have an opportunity for more intervention, and therefore more understanding on how to manage their autism.

Bailey: And through our work together, she quickly realized she was autistic so that changed her trajectory. It also turned out I was the first trans person she had ever met. And I really think that helped decrease the risk factors by seeing all those other people and knowing they are just like you.

Kelly: There is so much fear from therapists sometimes to make the diagnosis of autism…It's hard for a therapist to want to give a diagnosis for an adult. The majority of people that I work with can't afford to pay for food so there's no way they can pay out-of-pocket for an evaluation…I think it is important for people to have access to that.

Jose: [He] came to this country when he was in the 4th grade, barely speaking English. But by 6th grade, he was diagnosed with autism. There was never a lot of understanding on his part about autism. His parents did not really explain how he might be different than others in some ways.

Most adults who receive a late diagnosis, according to Leedham et al. (2020), report it as a positive experience. At the time of his suicidal attempt, Jose was also learning about his autism at age 45. A late diagnosis of autism is an additional risk factor of suicidality because this knowledge can have both a positive and/or negative impact on an individual (Atherton et al., 2022; Zener, 2019). Each of these clients experienced their autistic traits to the point of suicidality because they had not yet learned how to manage rigidity, sensory stimulation, masking, and/or the late diagnosis.

Life Changes and Transitions

Making a life change is stressful. Sometimes it is because there are many things to do and a lot of planning. Sometimes it is because there are so many emotions: excitement, fear,

anticipation, worry, pride, and/or insecurity. The clients in this study experienced many life changes, and some more dramatic than others. Changing jobs, losing jobs, and new jobs as well as moving homes with family, without family, to be with family, and to get away from family all occurred. In addition, some clients felt their transitions were positive while others felt the transitions were frightening.

Life Changes

Change is uncomfortable often because of transitioning away from what is comfortable or predictable. Leaving someone or something behind means there may be a gap or loss in one's life. During transitions such as into parenthood can be steps into a new role which brings uncertainty. Lastly, attempting new things and new places can be exciting and even adventurous while also being frightening and overwhelming.

> *Kelly: I think that transitional period or any transitional period was difficult for them. Even leaving their apartment, going to another location can be difficult. … That kind of transition plus having to talk to somebody at the disability office was very anxiety producing, and bringing up a lot of suicidal ideations. … Their partner's job was also hard to manage because the schedule would change a lot.*

Setting goals or expectations, whether they were achieved or not, allowed Bailey to move forward, and decrease some of her uncertainty about the future. Bailey had dropped out of college after attempting suicide, went to work, and got a transfer further away from her parents. This is when she decided to try therapy for the first time.

> *Bailey: …things started getting a little bit better. She was talking about gender stuff and coming to the realization she might be trans … she was in a new place and was trying to*

make new friends. … and through our work together, she quickly realized she was autistic.

Robin had dealt with abuse from both parents, and making changes was very difficult. Now they had changed jobs with a new schedule and a new location.

Robin: It was just hard to see the positive because it was overwhelmed by the new schedule and being in a new place and new location. They … moved soon after they had a new job. They moved to a new house, and that was extremely hard …because change in general. Like leaving their home and going other places, and changing their routine can be really hard.

Life changes and transitions can create a variety of responses. For Kelly, it created more anxiety but for Bailey it became a new start. And for Robin, their trauma was overwhelming everything positive that was occurring in their life. All of these experiences are very typical for someone going through change and transition. Their individual experiences, challenges, and support will create their future endeavors.

RQ2: What are the experiences of suicidality for individuals with autism?

Suicidality

All clients in this study have experienced suicidality in different ways. Many clients have experienced suicidal ideation for extended periods of time. Some clients made a suicide plan that was general or specific with intent, like Bob and Bailey believing they did not have the resilience to make it to age 30. Some clients attempted suicide unsuccessfully, often prior to meeting their therapist.

Suicidal Ideation

Several participants described suicidal ideation as a significant risk factor. Passive suicidal ideation is living with ideas of suicide all the time but taking no suicidal actions. Fortunately, research shows that suicidal ideation does not automatically mean that a suicidal attempt is imminent (Liu et al., 2020). A few clients have lived with ongoing suicidal ideation for years.

> *Bailey: … in middle school the passive suicidality began which led to the end of high school and college. This is when she was doing a lot of risky behaviors… not wearing a seatbelt … using substances, …amphetamines were her choice substance.*
>
> *Robin: Their suicidal ideation was chronic. There never was a time when we were together that they attempted suicide but they would get close…. The chronic pain was really intense. …They had difficulties with food so they would restrict themselves a lot.*
>
> *Kelly: [T]his client has suicidal ideation as part of their baseline. Most of the time they are thinking about suicide. But the way they are thinking about it depends on what is going on in their life… while I was working with them.*
>
> *Belle: Some self-harm years when they were in their teens … Just to clarify the way they think about it. They didn't want to be alive. They didn't see the purpose in being alive. They didn't see why they are here. They didn't want to exist really.*

Suicidal Plans

> *Jose: … was trying to find a place where he could be alone. He was drinking because*

he was having thoughts of running into traffic or going to a bridge and jumping off. Jose had never seen a therapist before and never really talked about his 'problems' before.

Bob: This client did not believe they would be alive at 30. The fact that they are 37, actually going to be 38, … they really didn't believe they were going to live this long. …I think they scared themselves of all that becoming a reality.

Robin: [U]sing medication was often paired with running out into traffic because they lived on a very busy street. So that was very frequent. But they also … had a gun …in the nightstand drawer next to the bed they slept in… [T]hat was also suicidal.

Bailey: Now she's only in her early 20s, so that suicidality continued until she was about 28 or 29. And that was when she decided, 'If I still feel this miserable by the time I'm 30, I'm checking out for good.'

Suicidal Attempts

Kelly: It was such a norm for them. I don't think they understood the real gravity of it. …When they overdosed, their partner ended up not taking them to the ER. And it was genuinely a situation where they could have died.

Jose: Another client had been on the streets with him and heard him talking about jumping off the bridge … He came back and told them at the shelter. … [Police] found [Jose] in the water at that bridge, and saved his life.

Shane: … was hospitalized for several suicidal attempts when he was younger. [I would] remove him from his situation; a little time away from Dad. I had such a good rapport

with this young man that I could talk him down and make safety plans with … his mom, to stay with good friends or relatives for a few days.

Robin: They have gotten close to attempting. … They were in high school [and] took themselves to the hospital. They said, "I feel like I am going to kill myself" … Since then, it has been an ongoing relationship with suicidal ideation.

These suicidality experiences show the intensity and complexity of emotion and trauma mixed with cognitive and personal factors. The range of emotions, the multitude of events both suicidal and non-suicidal that lead up to an attempt are very unique. The reason for suicidal ideation is a puzzle for each clinician to solve in hopes of creating a safe space for intervention before any attempt occurs.

Minimizing

Minimizing is considered a cognitive distortion, or a way that our minds change a pattern of thought by diminishing its importance (APA, 2022). Understanding when a topic of conversation is important or when it is more casual is a skill that is important for both the speaker and the listener, especially during a time of crisis or suicidality. Minimizing may be a way to avoid dealing with emotions, dismissing someone's rude behavior, or to shifting one's reality to a safer topic (Gilbert, 2011). Recognizing this behavior is crucial especially when the topic is suicidality as this could be a life-saving act. Here are a few examples the therapist-participants encountered.

Kelly: Sometimes they would just minimize … Like when they attempted [suicide], and they told me, it was more the way that they told me. It was something that happened, and now let's talk about something else. … This is important. We can't skip it, and not talk about it. Even when we did talk about it, it was very nonchalant.

Belle: On the Thursday session they were like I'm doing so good, we could just end early… Okay… and then Sunday, they ask for an extra session. Interesting. …Then they told me that well we couldn't really find a time because their work schedule is really hectic. … 'Thank you so much. I just wanted to let you know that my partner left me, and I'm safe. I just want to let you know I'm safe and this is really hard.' … I was reassured when we actually got to session.

Minimizing important subjects can be an opportunity, as seen above, for a skilled therapist to take the time to teach an individual with autism better skills in communication. Talking about difficult topics is challenging for everyone. Minimizing in these situations could cause strain on a relationship but more significantly could communicate the wrong intent to the inexperienced listener.

Mortality

When one is experiencing suicidality and questioning the purpose of their life, it includes more in-depth questions than simply staying alive. Mortality is when one examines the purpose and meaning of existence through the lens of growth, crises, and importance. Shane would make comments saying, *'I may as well not be here my dad's so mad at me', or 'He hates me. Why am I even here?'* Questioning one's purpose during or after a crisis can be just as important as questioning one's behavior to make significant change.

Bob: [They] don't have any family because most of them are dead. Doesn't really have any support or money, so it just continues to be a struggle to keep going… They just feel like giving up. 'What's the purpose of life?' 'Why am I doing this? Why do I keep doing this?'

Kelly: I think ever since they were a kid. I mean the way they talk about their childhood… For example, there was a time they decided they were no longer going to try to please their parents anymore because it doesn't matter. I'm going to get hurt anyway so I'm going to just rebel.

Every client in this study experienced at least one of the three levels of suicidality: suicidal ideation, suicidal plans, or suicidal attempts, and of course some experienced all three. Each level of suicidality is an important topic of conversation for both the speaker and the listener showing that minimizing a crisis can be dangerous. People think about the end of their life as the end gets closer, and at various times during their life, but it is common to consider one's mortality after a crisis.

RQ3: What suicidal factors are experienced by individuals with autism?

There are multiple types of suicidal factors that have been studied. There are risk factors for suicidality that show a need for concern, alarm, and compassion. There are protective factors for suicidality that provide relief, satisfaction and even happiness. There are suicidal factors that explain the feelings, actions, and decisions that are commonly present when an individual experiences suicidality. The suicidal factors experienced by individuals with autism in this study include three categories taken from the Interpersonal Theory of Suicide: belongingness, burdensomeness, and acquired capability (Joiner, 2005).

Belongingness

There are many influences that can help one maintain belongingness. However, there are risk factors that may cause one to lose their sense of belonging, or connection with others. According to the CDC (2025), these risk factors include death, discrimination, racism, and/or

social isolation. In addition, having and then losing one's employment, housing, or healthcare is very risky.

Family

Belonging to a family or a social group gives one a sense of pride and recognition. Belonging supports our sense of identity and allows us to develop into healthy adults. Losing this belongingness can be detrimental. Bob had lost his sense of belonging when they lost their family due to divorce and financial issues, and had no other support system. Robin's mom was so challenging she was a suicidal trigger for them.

> *Bob: I do know that since the divorce, the child's custody battle has been really difficult because they continue to have financial issues. … My client doesn't have any family because most of them are dead…. there have been really hard times during this battle. It's just draining everything out of me."*

> *Robin: Their mother moved in at one point, and that was a difficult change. Not great. The only reason that they did it was because, yes, they care about their mom, but also to help out financially. But their mother is a huge trigger for everything, so that was hard.*

Overall, the experiences of Bob and Robin showed that the lack of belongingness led them to the feeling of disconnection and instability. Bob had lost all of their original family and had no support. Bob was overwhelmed by being unable to financially support their new family and uncared for by their partner. Robin felt as if they should care about their mom and help her out, regardless of how difficult it was for their own well-being. The feelings of not belonging, being alone, or different can affect communication in relationships as well as have an impact on

one's mental health. Both of these clients had lost their sense of belonging, which in turn challenged their relationships, and put them at risk for suicidal behaviors.

Burdensomeness

Too much responsibility or adversity can feel like a weight that must be managed and can feel like a burden. Burdensomeness is the mistaken belief that one is a burden to others. This belief occurs most commonly from one's lack of ability to take care of themselves or perform day to day tasks, and needing others to assist or care for them. It is considered a mistaken belief because it is usually the victim who feels that they are a permanent burden but not necessarily the feeling from the person who cares for them. Not feeling able to complete regular tasks or maintain employment in a timely manner can lead to feelings of incompetence for some. Hearing a loved one talk about how they are a burden or how it's better for them not to be around are signs they are experiencing burdensomeness.

> *Belle: … when they broke up with their partner, they wanted to ask Mom for help … I don't know where I should live. I can't pay the bills on my own. My partner left me. Mom kept saying well your animals can't live with me. And you can use my car but you can't put any miles on it.*
>
> *Bob: They were trying to make some money here and there, trying to contribute but felt like they couldn't. That was a big deal not having their independence or agency…But it became more financial stress when they were on their own, and they couldn't provide for the baby, too. They left the marriage and then divorced.*

Belle felt their needs were just too much for their mom, creating more burden for Belle as they now had to worry that their mom could not manage helping Belle. Bob felt trapped by their

own life with a baby, no job, no money, no car and an absent partner. All three of these clients felt that they were a burden, unable to take care of their lives at that time of crisis, and needing to depend on someone who they believed didn't want to help.

Acquired Capability

Individuals who attempt suicide have often acquired the ability to fatally harm themselves, which is unusual because humans cannot do this without practice of painful and provocative behaviors. Repetitious harm to oneself takes practice and planning in order to take away the pain and fear of dying, and increase tolerance in preparation for suicide. Acquired capability is a concept that connects the lack of belongingness and the perceived burdensomeness to the act of suicide (Joiner, 2005). Individuals who have had prior suicidal attempts may lose the fear and pain of suicide, and therefore are considered a higher risk for future suicidal attempts. There are activities and professions that embrace violent, risky or impulsive behavior such as military combat, doctors/nurses, butchers, daredevil stunts, and first responders which is why their jobs are often considered higher suicidal risks.

Abuse

All of the clients in this study were abused in some form. Abuse is repeated painful experiences that can often lead to the abused individual decreasing their tolerance for pain, which is also a trait of acquired capability. This high tolerance to pain can become an easier path for a suicide attempt or even the desire to die. In other words, the individual who has been physically abused, for example, may be so tolerant to pain and fear that there would be no hesitation to hurt themselves. Abuse survivors do not always become abusers just as abuse survivors do not always harm themselves and/or commit suicide.

Substance Abuse

Using substances can encourage risky and/or impulsive behaviors often leading to a higher tolerance of fear and pain. Bailey's substance abuse was on-going.

> *Bailey: [She was using] especially through college to help her get through her rigorous program. …She was trying but every time she had … [an] event, she found that she had to drink a lot to make it through it or use substances beforehand…. Now she's only in her early 20s, so that suicidality continued.*

> *Bob: They were addicted to drugs. Their brother was addicted to drugs. I do feel like the worst was when they were using. When they are sober, it's a bit of a wake-up call. … [I] think there is a sense of resiliency.*

The three basic components of the *Interpersonal Theory of Suicide* are thwarted belongingness, perceived burdensomeness and acquired capability, and are a framework for suicidal factors, including individuals with autism (Joiner, 2005; Joiner et al, 2009). The ITS shows the importance of one's sense of belonging in a reciprocal relationship, and an awareness of the absence of close relationships can both be a suicidal risk factor. Thwarted belongingness and perceived burdensomeness can cause suicidal ideation. A World Health Organization study found that approximately two-thirds of individuals with suicidal ideation never make a suicide attempt (Nock et al., 2008). However, acquired capability and the desire to die must be present for an attempt to take place as presented in the ideation-to-action frameworks of suicidality like the ITS.

Evaluation of the Findings

From the researcher's perspective, all clients with autism spectrum disorder shared their emotional, traumatic, and transformative experiences of suicidality. There are commonalities among individuals with autism which include mental health, suicidality, and the three main tenets of Interpersonal Theory of Suicide (Belongingness, Burdensomeness, and Acquired Capability). The traits and behaviors among individuals with autism can vary in severity, illustrating that autism can appear differently in each individual.

The findings of Research Question 1 revealed that the risk factors related to suicidality and exhibited by individuals with autism are influenced by four components: mental health, relationships, traits of autism, and life changes and transitions. The finding in mental health showed that all clients were diagnosed with autism. This finding in mental health is consistent with the study by Kolves et al (2021), showing 90% of individuals with autism who were diagnosed with a psychiatric disorder, attempted or died by suicide.

The findings showed relationship trauma and the impact of abuse and trauma significantly disrupted the natural development of healthy relationships. According to Bowen's theory of family dynamics, multigenerational patterns of unhealthy boundaries can cause conflict and interfere with development (Kerr & Bowen, 1988). The findings showed that there were autistic traits that appeared as risk factors for suicidality for some clients. Individuals with autism may experience repetitive and/or restrictive behavior or experience sensory sensitivities, which may have an anxiety-producing effect, according to the DSM-V-TR (APA, 2022).

The findings for Research Question 2 reveal that suicidality is definitely prevalent amongst individuals with autism. The risk of suicidality for individuals with autism is higher than that for their non-autistic peers (Cassidy et al., 2014; Newell et al., 2023). All clients in this

study experienced at least one of the three levels of suicidality: suicidal ideation, suicidal plans, and/or suicidal attempts. In addition, clients showed behaviors of minimizing as well as contemplating mortality. The experiences of suicidality are very different for individuals with autism compared to their non-autistic peers (Dow et al., 2021; Jachyra et al., 2022).

The findings for Research Question 3 reveal the suicidal factors related to the ITS such as belongingness, burdensomeness, and acquired capability (Joiner, 2005). The risk factors for suicidality occur when belongingness falls away, perceived burdensomeness increases, and acquired capability occurs, which was revealed with multiple clients. Suicidality occurs with thwarted belongingness and perceived burdensomeness intersecting at acquired capability and the desire to die (Joiner, 2005). Risk factors were found to be loss of family or friends, abuse, and substance abuse.

When comparing Research Question 1, 2 and 3, there was a correlation in terms of the high prevalence of suicidality and the significant personal trauma of each client. Present with many clients was abuse or loss of a parent illustrating the lack of belongingness the client felt from family. There was a correlation between an autistic trait and a risk factor for suicidality (e.g., Kelly - rash - suicidal ideation). There was a positive correlation in terms of suicidality and psychotherapy. Several clients made comments of gratitude to their therapists for helping them. For example, two clients expressed their plans of suicide by age 30 which did not occur because of receiving therapy. Suicidality in individuals with autism has been found in this study to begin with abuse and trauma. Various factors increased the risk of suicidality, but healthy partnerships and therapy helped with positive outcomes for these individuals with autism.

Summary

The goal of this chapter was to present the findings of the research study and learn about the experiences of suicidality for individuals with level one autism. The chapter began by showing the trustworthiness of the study. Next the thematic analysis of the data from the responses of the participants was provided. From the research questions, participant interviews showed risk factors for suicide that commonly occurred amongst the clients, including mental health issues, abuse and trauma, unhealthy relationships, and the loss of belongingness. The data showed abusive family relationships that became traumatic incidents and relationships as adults.

There are risk factors that are common in individuals with autism that can cause anxiety-producing behaviors which lead to mental health issues. This chapter concluded with an evaluation of the findings in regards to each research question as well as any combination of findings between questions. Current research and the theoretical research of the Interpersonal Theory of Suicide was used to help identify risk factors of suicidality in adults with autism.

Chapter 5: Implications, Recommendations, and Conclusions

The purpose of this study was to learn about the factors that led to a high prevalence of suicidality amongst adults with level one autism spectrum disorder. The problem addressed the lack of individualized information about suicidality by using a qualitative, phenomenological approach. This study revealed individualized information about the experiences of suicidality from seven adults with autism. The interviews with therapists revealed resilient clients who experienced significant trauma and abuse. The results showed individuals with autism who had mental health issues, relationship trauma, overbearing autistic traits, ongoing suicidality, and experienced the phases of the Interpersonal Theory of Suicide (ITS Theory): lack of belongingness, thwarted burdensomeness, and acquired capability.

The first limitation relates to the participants' accounts of their clients' suicidality experiences. Interviews captured the experiences of clients who had had suicidal events as told by their therapists, perhaps causing an incomplete interpretation or the possibility of losing important information in retelling. The second limitation relates to the sample size of the study. Moustakas (1994) recommends an appropriate number for qualitative studies is between eight and ten participants whereas this study had only seven. A larger sample may have provided more variation in genders, locations, and/or suicidal experiences. The third limitation is the narrow representation of states in the USA. This was due to a lack of response during recruitment.

Confounding factor bias is the fourth limitation. Confounding factor bias affects the conclusions of a study due to interference with the research factors (e.g., autism and/or suicidality). In this study, some individuals identify their gender as a transwoman or as nonbinary who may or may not have a different experience being neurodivergent and/or suicidal due to their gender (Eustaquio et al., 2022; Hedley et al., 2022). Similarly, individuals who have

other physical or mental health conditions (e.g., fibromyalgia, arthritis, ADHD) can also be considered confounding factors, since these conditions may interfere with the interpretation of the results. Comorbidities are a risk factor for suicidality and may also cause relationship stress, isolation, and loss of belonging (Billakota et al., 2020; Van Orden et al., 2010). The fifth limitation is the analysis of codes and themes from interviews with participants. Due to the researcher's inexperience in this area, there is a possibility of human error. Despite these limitations, this study does take a step forward in understanding the lived experience of suicidality for adults with autism.

Three factors may have impacted the interpretation of the results. First, the use of a semi-structured interview allows more detailed and valuable open responses from participants, which includes more divergence. Second, qualitative data can be subject to bias by the interviewer or participant when discussing individual insights. And lastly, the interpretation of results can be affected by researcher bias.

This chapter shows results related to the problem and purpose of the study, results related to the research questions, contributions from the Interpersonal Theory of Suicide (ITS) framework, factors that influenced the interpretation of the results, and the literature on autism and suicidality. In addition, this chapter provides recommendations for practical applications of the results and future research, the most significant implications for society, and a conclusion, including the study's overall takeaway message.

Implications

Research Question 1: What are the experiences of individuals with autism when the risk factors for suicidality are present?

The findings of this qualitative research question showed that individuals with autism experience suicidality when risk factors are present, including abuse and trauma that can affect healthy relationships. The responses showed individuals with autism experience abuse and trauma in their family of origin, often continuing into their adult lives. The results from this research question contribute to the existing literature and aid in filling the research gap regarding the lived experiences of suicidality among individuals with autism.

The existing literature supports the prevalence of abuse among individuals with autism and its consequences (Cazalis et al., 2022; Pearson et al., 2023). The implication of this finding suggests that practitioners need to continue to be aware of unhealthy relationships that may have continued from childhood into adulthood. The trauma of long-term abuse and the importance of trauma-informed approaches impact mental health. This awareness for healthcare professionals is crucial as this type of trauma can lead to suicidality (Bayliss et al., 2022).

The findings showed how autistic traits impacted the daily lives of the clients. The experiences of the clients included misunderstandings, invalidation, frustration, and disruptions. The existing literature shows that people with autism have more life stress than people without autism, eventually leading to anxiety, depression, and suicidal ideation (Hedley et al., 2022; Pelton et al., 2023).

This finding implies that mental illness can disrupt one's quality of life, creating more behavioral concerns (Bayam et al., 2023; Benevides et al., 2020). Clinicians need to address both autism and mental health issues when clients present with serious issues (Lai & Baron-Cohen, 2015; Trundle et al., 2022).

Research Question 2: What are the experiences of suicidality for individuals with autism?

The abuse and trauma experienced by individuals with autism in this study was devastating, and led to suicidality of varying degrees. The results suggest that autistic adults experience suicidality as a chronic, long-term event versus a short-term crisis event. The results highlight the importance of mental health and healthcare professionals, especially those in emergency care, to continue awareness of interpersonal violence that can lead to suicidality by using effective screening tools (Jachyra et al., 2022). Trauma and negative life events effect relationships through interpersonal violence and victimization. Unfortunately, without effective therapy this type of trauma can lead to poor mental health and suicidality (Brown et al., 2017; Camm-Crosbie et al., 2019; Trundle et al., 2022). In addition, painful and provocative incidents are considered a risk factor for suicidality (Joiner et al., 2009; Van Orden et al., 2010).

The implication of these results encourages mental health and healthcare professionals to utilize thorough checklists and questionnaires for individuals who are experiencing suicidality upon entering healthcare (Camm-Crosbie et al., 2019; Cassidy et al., 2022). The existing literature does support the idea of tailored surveys for all individuals with autism who are experiencing suicidality when entering healthcare, including asking about self-harm, suicidal plans, being suicidal, and suicidal ideation. (Cassidy, Bradley et al., 2021; Cassidy, Robertson et al., 2020; Hedley et al., 2022; Howe et al., 2020).

The findings of the study show that all the clients experienced suicidality. At first glance, this may seem disappointing. Yet, it is also true that there is growing research indicating that suicidality among individuals with autism is a concern that needs to be addressed. This study helps illuminate the seriousness of this research which could lead to the needed funding.

Research Question 3: What suicidality factors are experienced by individuals with autism?

The Interpersonal Theory of Suicide (ITS) has contributed to the understanding of how one experiences suicide (Joiner, 2005; Joiner et al., 2009). The results of this study showed that all the participants experienced a fundamental suicidality factor represented by the ITS. Clients experienced thwarted belongingness, perceived burdensomeness, acquired capability (often from abuse), and/or the desire to die (Joiner, 2005; Joiner et al., 2009). Individuals with autism did have different suicidal experiences and a higher rate of suicidality when compared to their non-autistic peers (Jachyra et al., 2022; Newell et al., 2023).

The findings of significant trauma contributed to the existing literature on suicidality factors and autism. Having strong feelings of burdensomeness and belonging, in addition to life-long trauma, Pelton et al. (2020) learned that these feelings prompted suicidality. Moseley et al. (2024) found that suicidal plans were related to acquired capability, and past-year suicidal ideation was associated with burdensomeness.

The suicidality factors imply that individuals with level one autism do experience suicidal factors from ITS, but not necessarily all of them as expected (Joiner, 2005; Joiner et al., 2009; Van Orden et al., 2010). This study showed that factors varied among the individuals. For example, both Belle and Bob had a strong sense of perceived burdensomeness, but there was no failed belongingness present during their suicidality. In addition, most clients experienced familial abuse, but not all clients experienced burdensomeness. Both of these examples show that the factors are not all experienced to get to suicidality.

The most serious implication and consequence for society is the significant childhood trauma and abuse. It is heartbreaking to know that all clients in this study experienced this.

In addition to suicidality, many issues remain unresolved for individuals with autism, including but not limited to mental illness, gender fluidity, and physical comorbidities. More information, knowledge, and training are needed for public agencies, such as healthcare, education, and public safety (e.g., police, first responders), to assist individuals with both autism and suicide. More resources and strategies are needed for systemic change for both suicide prevention and autism awareness.

Recommendations for Practice

Mental health services on various levels need to be available for individuals with autism. Risk assessments for suicidality for individuals with autism are needed. Clinicians can create safety plans that promote self-worth, social inclusion, and fit individuals with autism (Goodwin et al., 2025). Collaboration with suicidality professionals on suicide prevention programs for individuals with autism, created by individuals with autism, would show compassion and understanding. Education about autism and suicide for all healthcare personnel and first responders, and for the general public, is needed (Hedley et al., 2022).

Access to assessment for adults who are interested in finding out if they are autistic needs to be more readily available. (Overton et al., 2024). The expectation for an adult to provide a developmental history from childhood, for example, can be unrealistic. In addition, cost, availability of a psychiatrist, accuracy of history, tracking down medical records, and convenience of testing sites are just a few of the issues that have delayed and/or discouraged individuals from being diagnosed later in life (Lai & Baron-Cohen, 2015; McDonald, 2020).

Psychoeducational information needs to be available for the neurodiverse that will help with communication, clarity and understanding. Domestic violence and abuse prevention needs

instruction that includes somatic education (body awareness), personal boundaries, dating and sexuality. Mental health literacy is important for both neurotypical and neurodiverse individuals. To support this, the mandated reporters can begin receiving training for abuse of the disabled.

Suicidality is a global crisis allowing suicide prevention programs to be a priority. It is imperative to have a suicide prevention program, specifically for individuals with autism, preferably created by individuals with autism. Suggestions include a program that allows immediate support and treatment so individuals with autism are not denied services, or given the wrong treatment or support (Camm-Crosbie et al., 2019; Cassidy, Goodwin et al., 2021). Prevention programs can also include information for healthcare professionals and first responders. Emergency departments can help identify suicidality in individuals with autism from questionnaires as well as from other factors, such as trauma and abuse, isolation, and social exclusion (Giannouchos et al., 2023; Griffiths et al., 2019).

Suicidal hotlines are a wonderful tool for those who need someone to talk to when in crisis. For individuals with autism, who are not always understood, one suggestion is to create a "warm line" to talk to someone about their concerns, even before they reach a crisis level. With communication differences apparent, an autistic person needs to be able to speak to another autistic person when possible.

Recommendations for Future Research

The goal of this study was to learn about the experiences of suicidality for individuals with level one autism. Results show many research areas of need and improvement for both suicidality and individuals with autism.

Autism spectrum disorder is a varied and complex disorder that affects individuals in a multitude of different ways. Although it may be challenging, it is important to attempt to get a full representation of the full autism spectrum for accurate research. Further research is needed in other subgroups of the autism spectrum (e.g., intellectual impairments, elderly, significant language impairments, young adults, etc.). Gender needs to be considered an important factor in autism research, regarding gender identities such as homosexuality, non-binary, and transsexuality (South et al., 2021).

Future research is needed on autism and the ITS. Findings show that the Interpersonal Theory of Suicide provides an accurate framework for individuals with autism who experience suicidality. However, more consistent results need to be gathered that may include individuals with autism and why they do not consistently progress through all phases of the theory.

Further research is needed in the area of suicide prevention for individuals with autism. Increasing access to programs, adjusting screening tools, and using preventive care strategies are often suggested but are not studied as often in order to determine their effectiveness overall. In addition, prevention programs should consider community issues such as unemployment, immigration, and poverty (Griffiths et al, 2019).

Conclusion

The problem for this study was the lack of individualized information about suicidality for individuals with autism. The findings showed that there were many risk factors present for those experiencing suicidality. Just as autism varies amongst individuals, so do the risk factors of suicidality. However, it bears repeating that the most impactful finding was that every client had experienced trauma and/or abuse. These factors negatively affected the decisions and

relationships of these clients in both youth and adulthood. This information is valuable as it can help in looking for ways in which autistic individuals could be better supported in abuse and violence prevention.

Communication is a concern for many individuals with autism. It is also difficult to match a client with a good therapist. Yet, every client in this study had seen a therapist regularly enough to discuss their own history, suicidality, and future goals. Regardless of the clients' emotional and traumatic life experiences, the clients maintained an element of gratitude for growth, therapy, and change. Believing and understanding that there is a possibility for a good life, that there is someone who cares, and wants to hear your story, presented itself as an empowering message for those who have not yet heard it. The findings showed that with positive therapeutic interventions, each client successfully avoided fatal suicide. Many therapists spoke about how much admiration they had for their clients and the incredible work they had done to improve their lives.

The unique perspective this study provided allowed individualized information about suicidality to be shared to build understanding and support for individuals with autism. The combined concepts of the ITS and autism are important to recognize. The ITS explains how and why suicide happens, a framework to understand it, and then hopefully help prevent it. There are many researchers who make the connections between autism and suicidality (e.g., Cassidy & Pelton, 2017; Moseley et al., 2022; Newell et al., 2023; Pelton et al., 2020).

The takeaway message of this study is that many improvements and changes are being made all the time to help and accommodate individuals with disabilities. Autism is challenging for many people to recognize and understand, and therefore needs more awareness and education

with a focus on serious topics like suicidality. Autism groups ask regularly to be represented in the decision-making for all changes. Funding sources need to recognize the needs of this growing group of neurodivergent individuals.

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Appendices

Appendix A: Consent Forms

Appendix B: Interview Protocols with resources

Appendix C: Recruitment Letter

Appendix D: Site Permission lLetter

Appendix E: Recruitment Flyer

National University IRB
9338 Lightwave Ave., San Diego, CA 92123
irb@nu.edu

Consent Form Revised

My name is Demetria Sumner Callejas, and I am a doctoral student at National University (NU).

I'm asking you to take part in a research study about adults with autism who have experienced suicidal thoughts or attempts. The name of this research is "Exploring the Factors of Suicidality in Individuals with Level One Autism Spectrum Disorder".

You may participate in this research if your client meets all of the following criteria:

1. They are diagnosed with autism spectrum disorder or Asperger's Syndrome **AND**
2. They have experienced suicidality (suicidal thoughts and/or suicide attempts) **AND**
3. They are age 18 or older.

I hope to include ten people in this research.
Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What you will be asked to do. If you agree to be in this study, you will be asked to do the following activities:

1. Attend a brief meeting to complete the consent form (approximately 15 minutes), or this may become part of the interview. Then email the signed copy to the researcher.
2. Complete a 45-60-minute interview with the researcher through Zoom or a recorded phone call about your client's experience(s) of suicidality and the risk factors that lead to their suicidality.
3. Complete a follow-up online interview for less than 30 minutes for any clarification of content, as needed.

During these activities, you will be asked questions about:

- Your name, position, and email.
- Your client's first name and last initial, age, gender, race, disabilities, and age of diagnosis.
- The state you live in currently.
- Your experiences with suicidal thoughts and attempts, and any risk factors that may have led to the experiences for you and / or your client.

Risks. Some possible risks include: Discomfort discussing suicide. Difficulty talking about suicide. Difficulty talking about living with suicidality and / or autism.

To decrease the impact of these risks, you can skip any question you do not wish to answer, skip any activity, or stop participation at any time.

Benefits. If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this research.

Recording. I would like to audio/video record your responses with Zoom during the interviews.

Mandated Reporting. My professional role outside of NU requires me to report suspicion of child or elderly abuse, suspicion of possible harm to self or others, and committed crimes to the appropriate authorities.

Confidentiality. I will keep the records of this study private and take reasonable measures to protect the security of all personal information. In any report I make public, I will not include any information that will make it possible to identify you or your clients. I will use pseudonyms for participant responses in the study. I will use an online security system as well as working from an exterior hard drive when needed. I will use a locked file cabinet for all paper documents. I will keep all study materials for three years, at which time they will be shredded.

Taking part is voluntary. Participation in this study is completely voluntary. You may quit at any time. You can disable the video function of the online meeting platform at any time.

If you have questions. Please ask any questions you have now. If you have questions later, you may contact me at dcallejas@currently.com .

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) via email at irb@nu.edu

Statement of Consent. I have read the above information and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____ Date _____

Your Name (printed) _____

Your email _____

Consent Form

My name is Demetria Sumner Callejas, and I am a doctoral student at National University (NU).

I am asking you to take part in a research study about adults with autism who have experienced suicidal thoughts or attempts. The name of this research is "Exploring the Factors of Suicidality in Individuals with Level One Autism Spectrum Disorder".

You may participate in this research if you meet all of the following criteria:

4. You are diagnosed with autism spectrum disorder or Asperger's Syndrome **AND**
5. You have experienced suicidality (suicidal thoughts and/or suicide attempts) **AND**
6. You are age 18 or older.

I hope to include ten people in this research.
Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What you will be asked to do. If you agree to be in this study, you will be asked to do the following activities:

4. Complete a 45-60-minute interview with the researcher online through Zoom about your experience(s) of suicidality and the risk factors that lead to your suicidality.
5. Complete a follow-up online interview for less than 30 minutes for any clarification of content.

During these activities, you will be asked questions about:

- Your name, age, gender, race, and disabilities.
- Age of diagnosis.
- The state you live in currently.
- Your experiences with suicidal thoughts and attempts, and any risk factors that may have led to these experiences.

Risks. Some possible risks include: Discomfort discussing suicide. Difficulty talking about suicide. Difficulty talking about one's autism.

To decrease the impact of these risks, you can skip any question you do not wish to answer, skip any activity, or stop participation at any time.

Benefits. If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this research.

Recording. I would like to audio/video record your responses with Zoom during the interviews.

Mandated Reporting. My professional role outside of NU requires me to report suspicion of child or elderly abuse, suspicion of possible harm to self or others, and committed crimes to the appropriate authorities.

Confidentiality. I will keep the records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. I will use pseudonyms for participant responses in the study. I will use an online security system. I will use a locked file cabinet for all paper documents. I will keep all study materials for three years; at which time they will be shredded.

Taking part is voluntary. Participation in this study is completely voluntary. You may quit at any time.

If you have questions. Please ask any questions you have now. If you have questions later, you may contact me at dcallejas@currently.com .

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) via email at irb@nu.edu

Statement of Consent. I have read the above information and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____ Date _____

Your Name (printed) _____

Interview Protocol

Edited questions for Therapists

Hello my name is Demetria Sumner Callejas. I am the researcher for this study, and your interviewer today. Thank you so much for agreeing to talk to me about your experiences with suicide with your adult autism clients. I have a few demographic questions for you.

*Make sure that the consent form is okay, and that there are no questions.

Demographic Questions

Full name. Client first name pseudonym. Age. Gender. Race. Disabilities. Age at diagnosis of autism.

Interview Meeting

Let's get started. This interview is expected to last 45-60 minutes. I am recording our discussion to make sure that I have complete information. I also want to let you know that there are no wrong answers. I am here to listen to your story. Remember everything is completely confidential.

- Do you have any questions before we begin?
- I have learned that there are risk factors for people who think and act suicidal. A risk factor is when one or more events or changes that happen in one's life make them think or act suicidal.
- Can you tell me about a time when a client felt suicidal or attempted suicide?

- Did you notice the risk factors and triggers ahead of time? Will you describe it to me?
- Please tell me what type of risk factors you have seen?
- What were the specific changes that happened in their life that made them feel suicidal? What did they feel? How did that make you feel?
- When they think about suicide are there certain people or events that made them think about suicide? Tell me more about that.
- What happened after their suicide experience? What helped them the most to recover?
- What is one thing you would tell someone who is recovering from a suicide attempt?
- Do you believe suicidal experiences are an issue among individuals with autism? Do you think it is more prevalent for those with autism? Why? Why not?
- Looking back on your experience with your client's suicidal experience, at what point do you think they started asking for help?
- What needs to change to help your client manage this experience better? What do you need to manage the situation better?
- What has the experience with your client been like **for you?**

- Is there anything that you would like to share with me that I did not ask?

Thank you so much for speaking to me today.

- How are you feeling right now? Is there anyone you need to talk to right now that I can help you contact? Are you feeling safe?

Interview Protocol

Initial meeting

Hello my name is Demetria Sumner Callejas. I am the researcher for this study, and I am your interviewer today. Thank you so much for agreeing to talk to me about your experiences with suicide. I have a few questions for you. Then, today let's talk about your consent form. I would like to make sure that you understand it, and see if you have any questions. And then we can set up a day and time for the interview. How does that sound?

Demographic Questions

Full name. Age. Gender. Race. Disabilities. Age at diagnosis of autism. The state you currently live in. How you heard about the study. Email address.

Consent form by section

Criteria. Discuss autism diagnosis, experienced suicidality, and age 18+.

Activities. A 45-60-minute interview online and recorded about risk factors of suicidality plus a short follow-up interview for any clarification of content.

Risks. Some possible risks include: Discomfort discussing suicide. Difficulty talking about suicide. Difficulty talking about one's autism.

To decrease the impact of these risks, you can skip any question you do not wish to answer, skip any activity, or stop participation at any time.

Benefits. If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this research.

Mandated Reporter. My professional role outside of NU requires me to report suspicion of child or elderly abuse, suspicion of possible harm to self or others, and committed crimes to the appropriate authorities.

Confidentiality. I will keep the records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. I will use pseudonyms for participant responses in the study. I will use an online security system. I will use a locked file cabinet for all paper documents. I will keep all study materials for three years; at which time they will be shredded.

Voluntary. Participation in this study is completely voluntary. You may quit at any time.

Any Questions?

Let's set up the day and time for the interview.

Before we exit, I wanted to thank you again for joining the study. I am a doctoral student at National University, and very excited about this project.

Interview Meeting

- Hi, it's nice to see you again. My name is Demetria. How are you today?
- Let's get started. This interview is expected to last 45-60 minutes. I am recording our discussion and taking notes to make sure that I have complete information. I also want to let you know that there are no wrong answers. I am here to listen to your story. Remember everything is completely confidential.
- Do you have any questions before we begin?

- I would like to make sure that you are in a safe and comfortable place to talk. Do you feel comfortable where you are?

- I have learned that there are risk factors for people who think and act suicidal. A risk factor is when one or more events or changes happen in your life that make you think or act suicidal. Have you experienced this? What type of risk factors have you had?
- Can you tell me about a time you felt suicidal or attempted suicide? What was that like for you? Will you describe it to me?
- Were there any specific changes that happened in your life that make you feel suicidal? How did that make you feel?
- When you think about suicide are there certain people or events that make you think about suicide? Tell me more about that.
- What was your experience after being suicidal? What helped you to recover? What is one thing you would tell someone who is recovering from a suicide attempt.
- If this one thing helped you recover, and it was no longer in your life, would that become a risk factor for you for suicide? Tell me about that.
- What do you think about your suicidal experience(s)? Do you believe it is an issue among individuals with autism? Why? Why not?
- Looking back on your experience, at what point do you think you started asking for help?

- Is there anything that you would like to share with me that I did not ask?
- How are you feeling right now? Is there anyone you need to talk to right now that I can help you contact? Are you feeling safe?

I have created a flyer of resources for you that I will email right now that you can contact if you feel you need someone to talk to.

RESOURCES

- **Suicide and Crisis Lifeline 988** 988lifeline.org

  Call or Text – Available 24 hours

- **Crisis Text Line** Crisistextline.org

  Text: **TALK** to 741741 for a trained counselor, free, 24/7

- **Veteran's Crisis Line** www.veteranscrisisline.net

  1-800-273-8255 press 1

- **The Trevor Project** LGBTQ crisis hotline

  TrevorLifeline 1-866-488-7386

  TrevorChat access through a computer 24/7

  TrevorText text START to 678-678 available 24/7

- **SAMHSA Treatment Referral Hotline** (Substance Abuse)

  1-800-662-HELP (4357)

- **RAINN National Sexual Assault Hotline**

  1-800-656-HOPE (4673)

Recruitment Email/Letter

Date

- Name of person providing permission, their contact information, and their title

Hello,

My name is Demetria Callejas, and I am a doctoral student at National University. I am conducting a research study to understand the experience of suicidality among adults with level one autism. I am asking for your assistance in using, sharing, and/or forwarding the information about the study. Here are the details.

I am recruiting individuals who meet all of these criteria:

7. Diagnosed with autism spectrum disorder or Asperger's Syndrome **AND**
8. Experienced suicidality (suicidal thoughts and/or suicide attempts) **AND**
9. Age 18 or older.

Adults who participate in this study, will be asked to do the following activities:

6. Attend a brief meeting to complete the consent form (approximately 15 minutes).
7. Complete a 45-60-minute interview with the researcher online through Zoom about the experience(s) of suicidality and the risk factors that lead to the suicidality.
8. Complete a follow-up online interview for less than 30 minutes for any clarification of content.

*Please fill out the attached Site Permission form. This will give me permission to forward a flyer to you about the study. Feel free to contact me with any questions or concerns you may have about this study.

Thank you.

Demetria Sumner Callejas

dcallejas@currently.com

SITE PERMISSION

Date:

To: National University IRB

My name is _____and I am _____

Professional Position / Title

from _____.

Place of Employment

I have received the letter requesting recruitment assistance from Demetria Sumner Callejas for her study on adult autism and suicidality. I understand that she is recruiting participants who meet all of the following criteria:

1. You are diagnosed with autism spectrum disorder or Asperger's Syndrome **AND**
2. You have experienced suicidality (suicidal thoughts and/or suicide attempts) **AND**
3. You are age 18 or older.

I grant permission for Demetria Sumner Callejas to do the following:

4. Attend a brief meeting to complete the consent form (approximately 15 minutes).
5. Complete a 45-60-minute interview with the researcher online through Zoom about your experience(s) of suicidality and the risk factors that lead to your suicidality.
6. Complete a follow-up online interview for less than 30 minutes for any clarification of content.

If you have questions and would like to reach the researcher, please do so at dcallejas@currently.com

Thank you.

_____ _____

Full Name and Contact Information

RECRUITMENT FLYER

JOIN OUR RESEARCH STUDY.

Share your experience.

You may participate in this research if you meet all of the following criteria:

1.You are diagnosed with autism spectrum disorder or Asperger's Syndrome **AND**

2.You have experienced suicidality (suicidal thoughts and/or suicide attempts) **AND**

3.You are age 18 or older.

If you are interested, contact me at dcallejas@currently.com