From Masking to Meaning: A Neuroaffirming Approach to Suicide Prevention in Autistic Youth

Kelly Kaciuba

Keywords: *Neuroaffirming, suicide prevention, autistic, youth*

Introduction

A positive autistic identity and sense of belonging may protect young autistic people against the dangers of self-harm, according to emerging data and community insights (Cooper et al., 2017). Autistic youth face an alarmingly high risk of suicidal thoughts and behaviours, elevating the issue to an urgent public health concern. Recent analyses indicate roughly one in four autistic young people have contemplated suicide, and around one in ten have attempted it. Autistic individuals are several times more likely to experience suicidality than their non-autistic peers; one comprehensive review found autistic people have up to an eightfold increased risk of death by suicide compared to the general population (O'Halloran et al, 2022). Troublingly, this heightened risk emerges even in childhood. New data suggest suicidality can begin at very young ages in this population; for example, a caregiver survey in the US found that over one-third of autistic children aged 8 or younger had expressed a desire to die or kill themselves (Kennedy Krieger Institute, 2024). In other words, suicidal thoughts and feelings are not confined to late adolescence or adulthood in autism; they can surface in preadolescence, necessitating proactive intervention well before the teenage years. In short, the confluence of high prevalence and early onset of suicidality in autistic youth demands immediate scholarly and clinical attention.

This article examines the importance of neuroaffirming identity development as an upstream strategy for suicide prevention in preadolescent autistic youth. We discuss how fostering self-acceptance, community connection, and resilience in late childhood could reduce risk factors before serious crises occur. The autism suicidality crisis has many causes, such as a high mental health co-morbidity rate. Half to three-quarters of autistic people have a co-occurring mental condition, usually anxiety or depression (Lai, et al. 2019). These mood and anxiety disorders, which are common in autistic kids, are known risk factors for suicidal thoughts and behaviour in the general population and likely contribute to autism's increased suicide risk (Brown et al., 2024; Brynie, 2012). Autistic children also face severe social challenges that might harm their mental health. Principal among these is peer bullying and victimisation. A national survey in the US found 63 per cent of autistic children had been bullied, compared to 12 per cent of their non-autistic siblings (Kennedy Kreifer Institute, 2024; Park et al, 2020). This shows that autistic youth are bullied three times more, underlining their social alienation and mistreatment. Chronic peer mistreatment is connected to juvenile sadness, anxiety, and suicide (Maiano et al., 2016). Beyond bullying, autistic preteens often face sensory-overloading classrooms and social demands that overwhelm them, causing ongoing stress in "a world not built for neurodivergent minds." According to minority stress models, external stressors, including limited access to resources, unfavourable societal attitudes, and disability-related discrimination, produce a pressure cooker that worsens internalising symptoms. Many of the issues that lead to suicidal despair in autistic children arise from the mismatch between autistic people and a culture that does not accept them. The social model of disability holds that environmental constraints and stigma cause disability-related issues more than neurobiology (Oliver, 2013). Unfortunately, traditional support systems have often overlooked or underperformed in addressing these issues. Clinicians and educators may neglect bullying, exclusion, and low self-esteem in favour of addressing autistic symptoms or concomitant conditions. Few validated instruments exist to quantify suicidality in autistic youth, and mainstream suicide prevention initiatives rarely adjust risk assessments or interventions (Cassidy et al., 2021). Many vulnerable preteens lack understanding and immediate support due to this gap. Psychiatric vulnerabilities, social victimisation, and cumulative environmental stress explain why an autistic child may feel hopeless and why typical interventions generally fail to lessen this risk.

Autistic self-advocacy, sometimes under the neurodiversity movement, has promoted autism as a natural neurological difference and a legitimate identity within human diversity for the past decade. According to the social model, many autism challenges stem from societal issues like inaccessible environments and stigmatising attitudes, and acceptance, accommodation, and pride in one's neurodivergent identity are crucial (Kapp et al., 2013). More research demonstrates that helping autistic youth accept and understand their autism might boost resilience and mental health (Rivera & Bennetto, 2023). Participation in autism community organisations or neurodiversity-positive initiatives that celebrate autistic qualities instead of stigmatising them increases self-esteem and sense of belonging in autistic people (Hus & Segal, 2021). Confident autistic adolescents who see themselves as "different but not less" had better mental health than those who internalise negative stereotypes. Cooper et al (2023) suggest that feeling proud to be autistic and connected to an autistic community can protect against stress, much like other minority groups' strong identities protect against prejudice. Boosting self-esteem and group

Corresponding Author: Kelly Kaciuba
Email: kelly.kaciuba@torrens.edu.au

Australian Counselling Research Journal ISSN: 1832-1135

connection may help autistic youth cope with bullying, loneliness, and self-doubt. They become more likely to seek assistance from like-minded individuals and reject society's negative portrayal. Finally, there is hopeful evidence that an autistic child's self-perception as a worthwhile neurodivergent individual with a meaningful identity, rather than a faulty "defective" version of normal, can dramatically impact their mental health.

In contrast, when autistic youth develop a negative self-concept or feel pressured to hide their true selves, the impact on mental health can be devastating. Many autistic children receive implicit or explicit messages from an early age that their natural ways of being are "wrong." They might be told not to flap their hands, to "tone down" their intense interests, or to act less autistic to fit in. Over time, these messages can foster internalised stigma, where the child begins to view their autism as a shameful defect. Internalised autism stigma has been directly linked to reduced wellbeing and increased depressive symptoms (Cage & Troxell-Whitman, 2019; Botha & Frost, 2020; Perry et al., 2022). A child who believes they are fundamentally flawed or a burden is more susceptible to hopelessness, self-loathing, and suicidal thoughts. Additionally, a common way of coping with stigma is camouflaging or masking one's autism, suppressing natural behaviours and imitating neurotypical actions to avoid rejection. While masking might offer short-term social benefits (or at least reduce overt bullying), a growing body of research shows it has significant long-term mental health costs (Alaghband-Rad et al., 2023). The effort to constantly "play neurotypical" is draining and anxiety-provoking, often leading to burnout. Studies have found that increased habitual camouflaging is linked to higher levels of depression and suicidality in autistic adults. For example, one study showed that autistic adults who reported more frequent camouflaging had significantly higher odds of suicidal thoughts and behaviours, even after accounting for other factors (Cassidy et al., 2018). The psychological toll of masking, feeling one must hide one's true identity to be accepted, can erode self-worth and social trust. Over time, the gap between the "false self" shown to the world and the genuine self can lead to deep loneliness and identity confusion. In short, when autistic youth feel unable to be themselves, their mental health often suffers severely. This dynamic helps explain why traditional interventions that aim to make an autistic child seem more "normal" might inadvertently cause harm, even if well-meaning, by reinforcing the child's belief that something is inherently wrong with them.

Given these insights, an effective early intervention for suicide prevention in autistic youth is neuroaffirming identity development. By helping autistic children build a positive understanding of their identity and by creating environments that validate rather than suppress their neurodivergence, we may protect them from some of the worst mental health outcomes. Our discussion is grounded in relevant psychological theories (social identity theory, self-determination theory, resilience theory) and the social model of disability, linking each to the experiences of autistic youth. We also introduce an innovative program, the "MegaMind" digital intervention, as a practical example of applying these principles. Finally, we consider implications for counsellors and psychotherapists working with neurodivergent young people, offering concrete recommendations for practice. Throughout, the tone remains optimistic and proactive: by embracing neurodiversity and supporting autistic children's identity development, counsellors can help lessen suffering and even save lives.

The Case for Neuroaffirming Identity Development in Early Intervention

Classic social identity theory (Tajfel & Turner, 1979) suggests that strong, positive group ties boost self-esteem and protect against external threats. This implies that when an autistic child views their neurotype as a desirable social identity rather than a source of shame, it can help them overcome stigma. A 2023 review by Rivera and Bennetto found that autistic individuals who identify with the autistic community have higher self-esteem and wellbeing and experience fewer adverse effects of minority stress on mental health. This highlights the importance of community belonging for autistic youth. Generally, feeling connected protects against youth suicide, but it is especially vital for autistic youth who find it hard to fit in. These children may not feel accepted or understood in conventional peer groups, so autistic social clubs, camps, mentorship programs, and online communities can support them in building connections. Research shows that autistic children who spend time together in inclusive environments often develop a deeper understanding of each other and feel relief from social pressure. Autistic-led peer programs report higher social enjoyment and lower anxiety compared to neurotypical therapist-led social skills groups (Shea et al., 2024). One study found that autistic youth said being with other autistic individuals helped them "finally relax" and stop worrying about being judged, which boosted their confidence (Crompton et al., 2020). Offer opportunities for autistic youngsters to meet and bond with their neurokin in person or online to strengthen their sense of shared identity. They can celebrate their interests, share experiences, and tackle problems with people who "get it". This friendship and collective identity can help individuals overcome feelings of estrangement.

Self-determination theory (Ryan & Deci, 2000) states that wellbeing blossoms when autonomy, competence, and relatedness are fulfilled. Traditional autistic treatments often disrupt these needs, such as harsh behavioural regimens that focus on conformity or tell children they must change to be accepted. Neuroaffirming identity interventions aim to meet these needs. Involving the child in support decisions and respecting their choices – such as letting them speak or type – can support autonomy. Encouraging a child's passion for computers or art and framing it as an opportunity to build competence is beneficial. The child might develop relatedness by having mentors or classmates who appreciate them. Early therapies should promote autistic youth to self-determine and feel capable and respected. Clinicians should replace conformity-focused goals like "make eye contact for X seconds" with more meaningful ones such as "identify your feelings and communicate them in a way that works for you" or "engage in a hobby with a friend." Giving autistic children a sense of control and recognising their mastery – even in unconventional areas – fulfils resilience-building psychological needs. Building resilience involves fostering a child's self-determination, helping them feel in control of their story and capable of growth. This aligns with evidence showing that self-advocacy and independence therapies can reduce sadness and improve coping in autistic teens, such as letting youth set objectives or make decisions.

The aim of resilience theory is to develop protective factors that help young people recover from hardship. Family support, school involvement, and other protective elements for autistic adolescents may require a neurodivergent perspective. For a student who feels alienated in a mainstream class, "school connectedness" may seem different, but connecting them with a scientific club mentor who shares their passion can be a similar experience. Developing a positive autism identity is like minority youth building a strong cultural identity to guard against discrimination. Resilience research suggests neurodivergent-friendly methods to promote protective processes, such as having a supportive adult, coping skills, and finding meaning or purpose. Counsellors may serve as the helpful adult who truly "sees" and accepts the young person. Learning coping skills might be framed as a "power-up" for a child who loves superheroes. The idea that "my brain is different and that's

what makes me an amazing artist/robotics builder" can give an autistic 11-year-old dignity and purpose. Besides reducing risk, resilience fosters strengths and hope. A neuroaffirming approach highlights strengths and prepares young people for challenges. Teaching an autistic preteen how to self-advocate for sensory breaks builds resilience: it helps them navigate a confusing world without giving up. The child learns "I can survive hard things, I have people who support me, and I have ways to cope that don't require me to pretend to be someone I'm not." These micro-interventions build resilience. This outlook might be the best defence against suicide.

Before showcasing an example program, it is important to recognise that embracing neurodiversity does not mean overlooking genuine struggles. Instead, it involves addressing these challenges in a way that respects the individual's identity. For example, suppose an autistic child experiences extreme anxiety. In that case, a neuroaffirming therapist will undoubtedly work on easing anxiety – but they will frame it as "let us find tools that help you feel better" rather than "let us fix your autistic behaviour". While this distinction may seem subtle, it is deeply significant for the child. One approach pathologises their autism, whereas the other supports them as a whole person. Research on clinical interventions increasingly acknowledges this difference. Murray et al. (2022), for instance, highlight the adaptation of cognitive-behavioural therapy for autistic youth by integrating special interests and visual techniques, both of which respect identity and enhance outcomes. Ultimately, mental health support for autistic youth should be additive (building new skills and supports), rather than subtractive (trying to remove core aspects of who they are).

MegaMind: A Digital Intervention Model

To illustrate these principles in practice, consider the "MegaMind" program, an early-stage digital intervention designed to promote resilience and positive identity in neurodivergent preadolescents. MegaMind is an 8-week program that operates in a Minecraft sandbox virtual environment. Why Minecraft? For one, Minecraft is a popular special interest for many kids, including those on the spectrum, and it offers an open-ended, creative space. MegaMind uses game-like activities to teach social-emotional skills. Players create an avatar and explore a virtual world, undertaking resilience-themed missions and challenges such as recognising stress and finding a "chill zone". Neurodivergent-friendly adjustments are made to the environment. Visual stimuli can be toggled to prevent sensory overload in the game, and children can communicate using text or emoji instead of voice chat.

MegaMind actively promotes children's individuality. MegaMind allows students to connect on their own terms, unlike typical social skills groups that teach eye contact or "appropriate" greetings. The game lets one child's avatar flap its wings or spin in circles, which is similar to stimming. The software celebrates each avatar's abilities in stories. A child who likes trains may build an avatar with a train suit and lead a group "train adventure" quest, turning a common autistic interest into leadership and pride. This is different from previous intervention strategies (like some ABA programs) that judged success by how similar the autistic child was to peers. MegaMind measures success through psychosocial growth, confidence, friendships, mood, and creative problem-solving. The program reduces real-world learning demands by providing a safe virtual space for autistic kids to be themselves. Early feedback from kids and parents shows that children feel "accepted" and "understood" in the game, maybe even making their first real friend.

MegaMind also includes peer mentoring, where older autistic teenagers or young adults trained as moderators act as "guides". Mentors share stories about their own experiences, gently demonstrate coping strategies (e.g. taking a break in a quiet virtual room when overwhelmed), and most importantly, affirm the younger participants' feelings. Based on social learning theory, children learn from somewhat older peers. MegaMind mentors show that "it's okay to be autistic; I've been where you are, and it gets better". Feeney et al (2021) found that near-peer mentoring can increase participation and reduce anxiety in autistic adolescent programs because mentees relate more easily to mentors than to adult therapists. A child may speak more openly in MegaMind if they know the mentor enjoys Minecraft or has struggled at school. These interactions help build a sense of community.

MegaMind innovates clinically by altering the environment, not the child. It aligns with the neurodiversity concept by creating a micro-environment that adapts to autistic youth rather than forcing them to adapt to a stressful reality. This modified setting aims to help them build confidence and skills that they can later apply in real life with counsellors and parents. The game features an AI "emotion coach" character that will gently check in if a child's avatar has been inactive or is typing repeated sad words in chat and ask, "I see you are quiet, want to use the mood spinner to convey how you feel?" For kids who struggle with open communication, a private in-game tool allows them to choose an emoji or colour to represent their emotions, providing facilitators with insight into who may need extra support. Digital augmentation supports findings that some autistic youths are more comfortable opening up to virtual agents or prompts than to doctors (who can unintentionally frighten or overwhelm them).

MegaMind is a prototype for a new wave of acceptance and strengths-based therapies, but such programs are still undergoing research and refinement. In limited samples, MegaMind (in-house) pilots demonstrated reductions in self-reported anxiety and improvements in "self-concept clarity" (the clarity with which participants view themselves and their traits) following the 8-week session. The programme represents a shift in autism intervention from compliance training to mental health promotion and identity support. It has great potential but requires technological resources, facilitator training in counselling and gaming, and careful customisation to each child's needs (not all autistic children like video games). We will soon examine practicalities and limitations. We begin by exploring what counsellors can incorporate from these techniques into their everyday practice.

Implications for Practice

Psychotherapists and counsellors who work with autistic children and adolescents can improve outcomes by adopting a neuroaffirming, identity-focused approach. This involves shifting from a pathology-based to a strength-based, collaborative paradigm. Practical implications and strategies for professionals include that therapists should focus on measuring mental health and skill development rather than on how "normal" an autistic young person becomes. Success might mean enhanced self-esteem, decreased suffering, or greater engagement with others on the child's terms, rather than merely trying to suppress autistic behaviours. Instead of attempting to eliminate hand-flapping or scripting, a therapist may encourage the child to use these behaviours strategically (such as flapping to calm down) or creatively. This reframe supports recent criticisms that masking autistic traits is unethical and ineffective (Botha et al., 2022). The goal is to help the child thrive as their true self, not to change them.

Encourage positive autistic discussion in therapy. This could involve teaching a young person about prominent autistic role models, reading age-appropriate books that celebrate neurodiversity, or openly discussing the child's own experiences with autism. Therapists may comment, "Your brain works a bit

differently, and that can be really cool – you notice things others miss!" Counsellors help reduce depression-causing internalised negativity by normalising and promoting neurodiversity. Some clinicians use identity mapping exercises, where the child creates a chart of things they like about themselves (such as "autistic," "honest," or "good with animals") and things they find difficult. Then, the therapist helps them see how many positives are connected to their autistic way of thinking.

Autistic children often think visually or benefit from structure. Visual aids in counselling improve communication and emotional understanding. For example, instead of relying solely on conversation therapy (which can be difficult for children who struggle with rapid language processing or introspection), a counsellor might use emotion cards, thermometers, or drawing exercises to help the child identify feelings. They could make a visual calendar or checklist for coping strategies (literally drawing "calm breathing," "hug a pillow," "play music" as options the child can pick). These techniques respect the child's communication style and lower the demands that can cause shutdowns.

Research shows that such augmentative assistance can significantly enhance emotional regulation in autistic children, as they feel understood on their own terms rather than failing to meet an all-verbal adult-centric approach. Using the child's interests in therapy is an excellent way to engage them. According to MegaMind, harnessing a child's passions, such as Minecraft, trains, astronomy, or anime, is a straightforward path to motivation and enjoyment. A counsellor might use a train analogy to discuss staying "on track" with coping skills or role-play with a favourite superhero to practise social skills. Content is less important than the message of respect: your interests matter. Therapy can use "circumscribed" interests to connect rather than pathologise individuals. The child becomes the expert in the room when talking about their subject, which can empower a child who feels incapable in other areas. Clinically, engaged and content children are better equipped to learn new coping strategies and perspectives. ills and views.

Support from peers can have a profoundly positive impact on someone's life. Counsellors should consider providing autistic clients with group activities or peer meetups. This could include organising a small social group for autistic preteens to play games in the therapy space or linking a family to autism community events. Even in one-on-one sessions, a counsellor can replicate some peer connection benefits by adopting a more collaborative approach, such as encouraging the child to teach them something, shifting the power dynamic, to foster a sense of equality. Where possible, involving autistic adults or older youth as co-facilitators or guest speakers can serve as sources of inspiration and comfort for young clients. Imagine a 10-year-old autistic child meeting a successful autistic university student who says, "I used to get really anxious in school too, here is what helped me." These connections provide hope and practical advice to enhance the therapist's support.

Bullying, sensory overload, and social failure traumatise many autistic youngsters. Additionally, they can experience "autistic burnout", a state of extreme exhaustion from prolonged masking or stress. Counsellors should view meltdowns, withdrawal, and regression as trauma or burnout symptoms, not random "problem behaviours". Trauma-informed sessions empower children with choices, create a sense of safety (perhaps by softening the lights or allowing breaks), and validate their emotional responses ("That noise hurt you, I see why you got upset" rather than scolding). It also involves teaching self-advocacy as a coping strategy: for instance, helping the child practise a word or signal to use when feeling overwhelmed, so adults can adjust the environment. Recognising autistic burnout may include convincing parents that a child who remains calm all day but erupts at home is overwhelmed. Counsellors can assist families in preventing crises with accommodations like a peaceful decompression hour after school. Seeing the autistic child's difficulties through a trauma and stress lens makes therapies more compassionate and effective, reducing blame and focusing on healing.

The success of MegaMind demonstrates that digital tools can improve therapy. Counsellors should be willing to incorporate apps, games, and other technologies to engage young clients. Use an autistic-friendly mood-tracking software or suggest a moderated online forum where the young person can practise social skills safely. Some autistic teenagers found telehealth services, which became popular during the COVID-19 pandemic, helpful because they could open up at home, often off-camera or via chat. Clinicians can offer such formats when suitable. Meeting the child where they are is essential. If a client enjoys texting, try therapeutic text check-ins between sessions. If they find face-to-face communication stressful, perhaps use a shared Google doc to "talk". Many games and applications teach emotional awareness, social problem-solving, mindfulness, and more in enjoyable ways. Professionals should evaluate these technologies for quality and use them to complement human interaction. However, a child's comfort with digital media can increase engagement and transfer therapeutic benefits into daily life.

Therapists and counsellors must also be open to learning from autistic people and updating their techniques. Neurodiversity-affirming practice is a relatively new paradigm, and it challenges several standard practices. Clinicians should learn about autistic culture and the Double Empathy problem, which turns social communication challenges into a two-way gap in comprehension. Importantly, autistic people can contribute valuable insight as teachers, advisors, or first-person accounts in literature. This teaches practitioners and models the collaborative mindset we aim to portray to clients ("I value autistic voices, and I'm not the sole expert here"). Traditional therapeutic methods like forced eye contact and punishment-based behaviour modification are increasingly considered harmful or ineffectual for long-term health. Keeping up with research and listening to autistic self-advocates helps one's practice benefit clients. Therapists should recognise neurodivergent clients as a minority group with genuine experiences and adjust their methods to be culturally competent.

These tactics can help counsellors build a holistic, flexible, and powerful therapy space for autistic youth. Nurture, not fix, takes precedence. Early research suggests that such an approach minimises negative outcomes like suicidality and actively promotes positive growth like confidence, self-knowledge, and hope, which are essential for long-term mental health.

Conclusion

As professionals in counselling and psychotherapy, we are uniquely positioned to influence the developmental path of autistic youth at risk of suicide. Research clearly shows that risk factors emerge early, but so do opportunities for prevention. By prioritising neuroaffirming identity development during preadolescence, we can address some of the underlying causes of despair, such as feelings of alienation, low self-worth, and ongoing stress caused by having to pretend, before they become ingrained in adolescence. Grounded in social identity theory, self-determination theory, resilience research, and the social model of disability, this approach reminds us that health is not just the absence of illness but the presence of positive connection and self-esteem. Initiatives like the MegaMind program demonstrate how we can creatively apply these principles, combining psychology, technology, and community-building to support young people in ways that are engaging and authentic to them. Although such

programs are still evolving, they offer a glimpse into a future where an autistic 10-year-old might confidently say, "I like who I am," and genuinely mean it; an outcome that could, quite literally, save their life. For practitioners, the challenge is to incorporate these insights into everyday practice: to be that counsellor who not only treats a child's anxiety but also affirms their right to be different; to guide families in not just accommodating autism but celebrating it; and to advocate for systemic changes in schools to become more inclusive and understanding. It involves supporting our clients beyond therapy, perhaps consulting with a teacher about bullying issues or assisting families in finding neurodiversity-affirming support groups. The small practical steps we take today in clinics, schools, and community spaces can help build a safety net of acceptance around these young individuals. In essence, preventing suicide among autistic youth demands a fundamental shift in how we approach early intervention. It's not enough to solely target problematic behaviours or co-occurring symptoms in isolation. We must proactively foster protective factors, especially a secure sense of identity and belonging. This preventive approach recognises autistic children not as fragile beings needing correction, but as resilient individuals who can thrive when provided with the right supports. It's about acknowledging their humanity and individuality, which in turn helps them imagine a positive future for themselves. Suicide prevention in this context is therefore about more than crisis response, it's about nurturing strength and pride from an early age. By igniting that spark of self-acceptance and connection, we can help ensure that neurodivergent youth not only survive but flourish, feeling valued and understood. This is both the challenge and the promise of embracing neurodiversity within our future mental health strategies. It's a challenge we, as a professional community, must urgently meet, and a promise we can deliver through empathy, innovation, and collaboration with those who matter most: the autistic young people themselves.

References

Alaghband-rad, J., Hajikarim-Hamedani, A., & Motamed, M. (2023). Camouflage and masking behavior in adult autism. In *Frontiers in Psychiatry* (Vol. 14). https://doi.org/10.3389/fpsyt.2023.1108110

Botha, M., Dibb, B., & Frost, D. M. (2022). "Autism is me": an investigation of how autistic individuals make sense of autism and stigma. *Disability and Society*, *37*(3). https://doi.org/10.1080/09687599.2020.1822782

Botha, M., & Frost, D. M. (2020). Extending the Minority Stress Model to Understand Mental Health Problems Experienced by the Autistic Population. *Society and Mental Health*, *10*(1). https://doi.org/10.1177/2156869318804297

Brown, C. M., Newell, V., Sahin, E., & Hedley, D. (2024). Updated Systematic Review of Suicide in Autism: 2018–2024. *Current Developmental Disorders Reports*, *11*(4), 225–256. https://doi.org/10.1007/s40474-024-00308-9

Cage, E., & Troxell-Whitman, Z. (2019). Understanding the Reasons, Contexts and Costs of Camouflaging for Autistic Adults. *Journal of Autism and Developmental Disorders*, *49*(5). https://doi.org/10.1007/s10803-018-03878-x

Cassidy, S. A., Bradley, L., Bowen, E., Wigham, S., & Rodgers, J. (2018). Measurement properties of tools used to assess suicidality in autistic and general population adults: A systematic review. In *Clinical Psychology Review* (Vol. 62). https://doi.org/10.1016/j.cpr.2018.05.002

Cooper, K., Russell, A. J., Lei, J., & Smith, L. G. E. (2023). The impact of a positive autism identity and autistic community solidarity on social anxiety and mental health in autistic young people. *Autism*, *27*(3). https://doi.org/10.1177/13623613221118351

Cooper, K., Smith, L. G. E., & Russell, A. (2017). Social identity, self-esteem, and mental health in autism. *European Journal of Social Psychology*, *47*(7). https://doi.org/10.1002/ejsp.2297

Corden, K., Brewer, R., & Cage, E. (2021). Personal Identity After an Autism Diagnosis: Relationships With Self-Esteem, Mental Wellbeing, and Diagnostic Timing. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.699335

Crompton, C. J., Ropar, D., Evans-Williams, C. V. M., Flynn, E. G., & Fletcher-Watson, S. (2020). Autistic peer-to-peer information transfer is highly effective. *Autism*, *24*(7). https://doi.org/10.1177/1362361320919286

Feeney, K. E., & Burke, S. L. (2021). The role of mentorship on social engagement among adolescents with autism spectrum disorders. *Research in Autism Spectrum Disorders*, *88*. https://doi.org/10.1016/j.rasd.2021.101842

Hus, Y., & Segal, O. (2021). Challenges surrounding the diagnosis of autism in children. *Neuropsychiatric Disease and Treatment*, *17*. https://doi.org/10.2147/NDT.S282569

Kapp, S. K., Gillespie-Lynch, K., Sherman, L. E., & Hutman, T. (2013). Deficit, difference, or both? Autism and neurodiversity. *Developmental Psychology*, *49*(1). https://doi.org/10.1037/a0028353

Kennedy Krieger Institute. (2024, April 4). *New research shows alarming number of suicidal thoughts among young children with Autism Spectrum Disorder.* Center for Development and Learning.

Lai, M. C., Kassee, C., Besney, R., Bonato, S., Hull, L., Mandy, W., Szatmari, P., & Ameis, S. H. (2019). Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis. *The Lancet Psychiatry*, *6*(10). https://doi.org/10.1016/S2215-0366(19)30289-5

Maïano, C., Normand, C. L., Salvas, M. C., Moullec, G., & Aimé, A. (2016). Prevalence of School Bullying Among Youth with Autism Spectrum Disorders: A Systematic Review and Meta-Analysis. In *Autism Research* (Vol. 9, Issue 6). https://doi.org/10.1002/aur.1568

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

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability and Society*, *28*(7). https://doi.org/10.1080/09687599.2013.818773

Park, I., Gong, J., Lyons, G. L., Hirota, T., Takahashi, M., Kim, B., Lee, S. Y., Kim, Y. S., Lee, J., & Leventhal, B. L. (2020). Prevalence of and factors associated with school bullying in students with autism spectrum disorder: A cross-cultural meta-analysis. In *Yonsei Medical Journal* (Vol. 61, Issue 11). https://doi.org/10.3349/ymj.2020.61.11.909

Perry, E., Mandy, W., Hull, L., & Cage, E. (2022). Understanding Camouflaging as a Response to Autism-Related Stigma: A Social Identity Theory Approach. *Journal of Autism and Developmental Disorders*, *52*(2). https://doi.org/10.1007/s10803-021-04987-w

Rutherford, C. (2012). "Effectiveness of functional communication training using augmentative and alternative communication on the challenging behaviour of children with autism." University of Western Ontario: School of Communication Sciences and Disorders.

Rivera, R. A., & Bennetto, L. (2023). Applications of identity-based theories to understand the impact of stigma and camouflaging on mental health outcomes for autistic people. In *Frontiers in Psychiatry* (Vol. 14). https://doi.org/10.3389/fpsyt.2023.1243657

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1). https://doi.org/10.1037/0003-066X.55.1.68

Shea, L. L., Wong, M. Y., Song, W., Kaplan, K., Uppal, D., & Salzer, M. S. (2024). Autistic-Delivered Peer Support: A Feasibility

Study. *Journal of Autism and Developmental Disorders*, *54*(2). https://doi.org/10.1007/s10803-022-05816-4
Tajfel, H., & Turner, J. (2023). An Integrative Theory of Intergroup Conflict. In *Organizational Identity*. https://doi.org/10.1093/oso/9780199269464.003.0005