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Understanding Psychiatrists' Knowledge and Attitudes to Suicidality in Individuals with Autism Spectrum Disorder

ABSTRACT

Background: Several studies have demonstrated that individuals with autism spectrum disorder (ASD) are at a significantly higher risk of suicide, with over 7.5 times increased likelihood of dying by suicide and higher rates of suicidal ideation. The present study aimed to examine the perspectives and awareness of psychiatrists regarding suicidal behavior in individuals with ASD.

Methods: To achieve this, an online survey was developed to assess clinicians' practices in evaluating suicidal thoughts and behaviors in individuals with ASD.

Results: A total of 143 psychiatrists, including 55 general adult psychiatrists and 88 child and adolescent psychiatrists, completed the cross-sectional survey. The results of the study revealed that clinicians reported lower rates of suicidal ideation and behavior in individuals with ASD compared to those without ASD ($P < .05$). Furthermore, it was found that the usage of screening tools for assessing suicidal behavior was significantly lower in the ASD group ($P < .05$).

Conclusion: The study aimed to investigate psychiatrists' knowledge and screening practices regarding ASD and emphasize the importance of increasing knowledge and implementing effective screening and intervention practices to address the risk of suicidality in individuals with ASD.

Keywords: Autism, suicidal behavior, general adult psychiatrists, child and adolescent psychiatrists, knowledge

Introduction

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that manifests in childhood and has lifelong impacts on various functional areas. Individuals with ASD and their families face significant challenges due to the nature of the disorder and the presence of comorbid psychiatric conditions.[1,2] In addition to experiencing difficulties in education, work, independent living, and peer relationships throughout their lives,[3] individuals with ASD have a higher susceptibility to psychiatric disorders such as depression and anxiety compared to the general population.[4] Recent studies have drawn attention to the issue of suicidal ideation and behavior among individuals with ASD. Research has shown an increased prevalence of suicide-related deaths and suicide attempts in this population.[5,6] While assessing suicidal ideation and behavior in individuals with ASD poses challenges, studies have indicated a link between autistic traits and suicidal thoughts/behavior.[7,8] Significantly higher rates of suicidal ideation and behavior have been observed among individuals with ASD compared to the general population or those with other psychiatric disorders.[8] This increase becomes particularly pronounced after the age of 10, especially among individuals with low socioeconomic status.[9] Suicidal thoughts and behaviors have been found to be 50% more prevalent in individuals with ASD compared to the general population, with suicide-related deaths occurring 3-7 times more frequently.[3,10,11] Moreover, it has been noted that autism symptoms are associated with suicidality even without a formal diagnosis of ASD.[7] The presence of an autism

Murat Eyuboglu[1]
Begum Sahbudak[2]
Damla Eyuboglu[1]

[1]*Department of Child and Adolescent Psychiatry, Eskisehir Osmangazi University, Medical School, Eskisehir, Turkey*
[2]*Manisa Mental Health and Diseases Hospital, Manisa, Turkey*

Corresponding author:
Murat Eyuboglu
meyuboglu@ogu.edu.tr

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diagnosis itself acts as a risk factor for suicide, independent of comorbid psychiatric conditions and sociodemographic characteristics.[12] Recent findings suggest that ASD, in addition to other known risk factors, may pose a specific risk for suicidal behavior. A population-based study conducted in Sweden demonstrated that individuals with autism had a higher rate of suicide-related deaths compared to the general population.[3] Furthermore, individuals with autism exhibit higher levels of suicidality compared to both the general population and individuals with other psychiatric disorders.[7] Lifetime prevalence rates of suicidal ideation in individuals with ASD have been reported as high as 66%, significantly surpassing rates observed in the general population (17%) and individuals with psychosis (59%).[13]

Despite the growing body of research on the association between autism and suicidal behavior, there remains a lack of studies exploring effective methods for identifying and mitigating the risk of suicide in individuals with ASD.[6] While it is believed that adaptations to existing practices are necessary for assessing and managing suicide risk in individuals with ASD,[14,15] there is currently no established roadmap for emergency service practices specific to this disorder. Furthermore, clinicians may feel ill-equipped to evaluate and intervene in suicidal behavior among individuals with ASD due to the absence of adequate scales to screen for autism-specific suicidal behavior and the challenges posed by the nature of the disorder in establishing social connections.[14] As research on autism and suicide continues, it is imperative for clinicians to enhance their evaluation of suicidal behavior and intervention skills in this population. Only a limited number of studies have explored the attitudes and knowledge of mental health professionals concerning ASD and suicidal behavior. Jager-Hyman et al[6] observed differences in the practical approaches of mental health professionals when assessing suicide risk in individuals with and without ASD. The researchers found that clinicians in the mental health field expressed a lower level of confidence in evaluating suicide risk in individuals with ASD and utilized safety plan interventions less frequently for these individuals. Another study conducted with mental health professionals working in pediatric emergency services revealed that participants felt insufficiently equipped to assess suicidal behavior in individuals with ASD, with fewer than half of them identifying autism as a risk factor for suicide.[15]

MAIN POINTS

- *Psychiatrists reported lower rates of suicidal ideation and behavior in individuals with autism spectrum disorder (ASD) compared to those without ASD, indicating that they perceive suicidal behavior as less prevalent in individuals with ASD. This perception contrasts with several studies that suggest higher rates of suicidal behavior in individuals with ASD compared to the general population.*
- *Clinicians reported less use of screening tools to evaluate suicidal behavior in individuals with ASD. The limited use of these tools may contribute to clinicians failing to detect additional conditions due to the belief that the risk of suicide is not high in individuals with ASD.*
- *Safety plan interventions were found to be used less frequently in cases of ASD, with only 7% of clinicians applying them specifically to individuals with ASD, suggesting that suicidal behavior, which can be comorbid and have severe consequences in individuals with ASD, may be overlooked.*
- *The study highlights a need for specific ASD-suicide risk screening tools, training for psychiatrists, and adapted intervention techniques.*

Our study aimed to investigate the knowledge and attitudes of clinicians working with children, adolescents, and adults regarding suicidal behavior in individuals with and without ASD. Additionally, we aimed to assess the proficiency levels of psychiatrists in the evaluation and intervention processes related to suicidal behavior in individuals with and without autism. Furthermore, we sought to explore the utilization of a safety plan intervention, which has demonstrated effectiveness in reducing suicide risk and enhancing treatment adherence among neurotypical individuals.[16,17] By examining how clinicians currently employ existing practices and intervention tools for addressing suicidal behavior in individuals with ASD, we aimed to contribute to the development of future methods or adaptations in this field.

Material and Methods

Study Participants and Procedures

This study was conducted from May 2022 to September 2022 at the Eskisehir Osmangazi University Medical School (Noninvasive Clinical Researches Ethics Committee; October 16, 2020/No. 19). After obtaining approval from the research ethics committee, clinicians residing in the country were invited to participate in the study through an e-mail containing a link to an online form. The link remained accessible for approximately 4 months, and a reminder e-mail was sent to participants during this period. Prior to completing the anonymous online form, participants were asked to read and provide their consent. While all participants had experience evaluating individuals with ASD, it was not a requirement for them to exclusively work in this area. Data regarding the number of individuals who declined to participate due to technical issues with the web link could not be determined.

Measures

As there are no standardized scales used in our country to assess knowledge and attitude of clinicians to suicidality in individuals with ASD, the authors created an online form for data collection. The online form consisted of 3 parts and a total of 23 questions aimed at evaluating the knowledge, attitudes, assumptions, and intervention practices of clinicians regarding suicidal ideation and behavior in individuals with and without ASD. The first part of the form gathered demographic information about the clinicians. In the second part, clinicians were asked questions pertaining to individuals without ASD in their clinical practice. The third part focused on questions specifically related to individuals with ASD. The form included questions with binary (yes/no) responses, such as whether standardized scales were used to evaluate suicidal ideation/behavior in their clinical practice. It also included questions with a triple Likert-type response scale (1: disagree, 2: undecided, 3: agree), for instance, assessing participants' self-perceived competency in evaluating suicidal ideation or behavior in individuals with autism. The form took approximately 10 minutes to complete.

Statistical Analysis

The data obtained from the study were analyzed using IBM Statistical Package for the Social Sciences Statistics software version 23.0 (IBM SPSS Corp.; Armonk, NY, USA). Descriptive statistics were utilized to

present demographic data, such as age, gender, and expertise of the participants. Continuous variables were expressed as mean (SD), while categorical variables were presented as numbers and percentages. Pearson's chi-square test and Fisher's exact test were employed to examine categorical variables. Paired *t*-tests or Wilcoxon rank-sum tests were conducted for continuous variables, while McNemar's test was used for categorical variables to evaluate differences in responses between clinicians regarding individuals with and without ASD. Statistical significance was determined by *P* values less than .05.

Results

The sociodemographic data about 143 mental health specialists and residents participating in the study are given in Table 1. Of them, 61.5% (n = 88) of the participants were child and adolescent psychiatrists and residents (63 females, 25 males), and 38.5% (n = 55) were general adult psychiatrists and residents (35 females, 20 males). The mean age of the participants was 34.1 (SD = ± 6.4). We inquired with participants about the proportion of individuals with ASD they encountered in their clinical practice relative to their overall patient population. The majority of the participants stated that the ratio of individuals with ASD in their clinical practice was below 20% (Table 1).

When the participants compared individuals with ASD and those without ASD, they stated that suicidal thoughts and behaviors were less common in individuals with ASD (Table 2). Also, the participants stated that they used less standardized scales to evaluate suicidal behavior in individuals with ASD (Table 2).

When the participants were separated as child and adolescent psychiatry residents and specialists, it was determined that the 2 groups did not differ regarding the scale used in evaluating suicidal behavior in individuals with autism (P = .33, χ^2 = 1.284). Also, there was no significant difference between the general adult psychiatry residents and the specialists regarding the frequency of suicidal thoughts in individuals with autism (P = .56, χ^2 = 1.671).

The findings of the participants regarding the attitudes, thoughts, and self-efficacy levels of individuals with ASD are shown in Table 3. A significant portion of the participants stated that suicidal thoughts and behaviors were not increased in individuals with ASD compared to healthy individuals. It was observed that only 17.5% (n = 25) of participants felt competent to evaluate suicidal thoughts and behaviors in individuals with autism. Seventy-three percent of the participants who reported low self-efficacy reported that they did not know how to assess the risk of suicidal behavior in the ASD group, and 15% reported facing challenges in making inquiries about suicidal thoughts and behaviors in individuals with ASD due to difficulties in social communication caused by the nature of the disorder.

Regarding the safety plan intervention used in individuals with suicidal behavior that was shown to reduce the risk of suicide in addition to adherence to treatment, 24.5% (n = 35) of the participants said they had never heard of the safety plan intervention, 25.2% (n = 36) stated that they heard about this intervention but did not apply it, 43.3% (n = 62) stated that they applied it in cases without ASD, and 7% (n = 10) stated that they applied it in individuals with ASD. Safety plan intervention application was significantly lower in the ASD group (McNemar test, chi-square: 34.3, P < .001). Most participants (84%, n = 120) agreed that the intervention against suicidal ideation and behavior should be modified considering autism-specific changes (Table 3). No significant difference was observed in the thoughts and attitudes of the 2 groups (residents and specialists) regarding individuals with ASD (Table 3).

Table 1. Characteristics of the Participants

Gender, n (%)	
Male	45 (31.5)
Female	98 (68.5)
Age (Years), Mean (SD)	
Total	34.1 (SD = 6.4)
Male	35.0 (SD = 6.9)
Female	33.7 (SD = 6.2)
Profession, n (%)	
Child and adolescent psychiatrists	65 (45.5)
General adult psychiatrists	44 (30.8)
Child and adolescent psychiatry residents	23 (16.1)
General adult psychiatry residents	11 (7.7)
Ratio of Patients Diagnosed with ASD to all Patients, n (%)	
<20%	114 (79.7)
20%-39%	23 (16.1)
40%-59%	4 (2.8)
≥ 60%	2 (1.4)

ASD, autism spectrum disorder.

Table 2. Clinicians' Opinions on Suicidal Behavior in Individuals With and Without Autism Spectrum Disorder

		Individuals With ASD n (%)	Individuals Without ASD n (%)	*P*
What percentage of your patients exhibit suicidal behavior?	<10%	124 (86.7)	73 (51)	<.001[a]
	10%-19%	13 (9.1)	35 (24.5)	
	20%-29%	2 (1.4)	20 (14)	
	30%-39%	3 (2.1)	7 (4.9)	
	40%-49%	1 (0.7)	4 (2.8)	
	> 50%	0 (0)	4 (2.8)	
Do you use a standardized scale to evaluate suicidal behavior?	Yes	4 (2.8)	20 (14)	<.001[b]
	No	139 (97.2)	123 (86)	

ASD, autism spectrum disorder.
[a]Wilcoxon signed rank-sum test.[b]McNemar test.

Comparing the responses of child and adolescent psychiatrists and general adult psychiatrists based on the questions presented in Table 3, a significant difference was noted between child and adolescent and general adult psychiatrists regarding 1 specific question. Notably, 36.4% of general adult psychiatrists believed that individuals with ASD exhibited suicidal behaviors more frequently than healthy individuals, while only 28.4% of child and adolescent psychiatrists shared this perspective (P = .022, χ^2 = 7.664).

Discussion

Our study focused on examining the knowledge and attitudes of clinicians, specifically psychiatrists, regarding suicidal ideation and behavior in individuals with ASD. To the best of our knowledge, our

Table 3. Clinicians' Attitudes and Behaviors Toward Suicidal Behavior in Individuals with Autism Spectrum Disorder

		Total (N = 143) n (%)	Residents (N = 34) n (%)	Psychiatrists (N = 109) n (%)	*P*	χ^2
Suicidal thoughts are more common in individuals with ASD than in healthy individuals.	(1) disagree	52 (36.4)	12 (35.3)	40 (36.7)	.54	1.214
	(2) undecided	53 (37.1)	15 (44.1)	38 (34.9)		
	(3) agree	38 (26.6)	7 (20.6)	31 (28.4)		
As the severity of ASD increases, the frequency of suicidal thoughts increases.	(1) disagree	90 (63)	21 (61.8)	69 (63.3)	.71	0.68
	(2) undecided	36 (25.2)	10 (29.4)	26 (23.9)		
	(3) agree	17 (11.9)	3 (8.8)	14 (12.8)		
Suicidal behaviors are more common in individuals with ASD than in healthy individuals.	(1) disagree	51 (35.7)	12 (35.3)	39 (35.8)	.40	1.83
	(2) undecided	47 (32.9)	14 (41.2)	33 (30.3)		
	(3) agree	45 (31.5)	8 (23.5)	37 (33.9)		
As the severity of ASD increases, the frequency of suicidal behaviors increases.	(1) disagree	81 (56.7)	20 (58.8)	61 (56.0)	.77	0.50
	(2) undecided	40 (28)	8 (23.5)	32 (29.3)		
	(3) agree	22 (15.4)	6 (17.6)	16 (14.7)		
Suicidal thoughts/behaviors are more common in individuals with ASD who self-injure.	(1) disagree	30 (21)	9 (26.5)	21 (19.3)	.61	0.99
	(2) undecided	41 (28.7)	10 (29.4)	31 (28.4)		
	(3) agree	72 (50.4)	15 (44.1)	57 (52.3)		
Autism-specific changes should be made in the suicide safety plan intervention.	(1) disagree	3 (2.1)	0 (0)	3 (2.7)	.55	1.19
	(2) undecided	20 (14)	4 (11.8)	16 (14.7)		
	(3) agree	120 (84)	30 (88.2)	90 (82.6)		
Do you find yourself competent in evaluating suicidal thoughts/behaviors in individuals with ASD?	(1) not competent	66 (46.2)	21 (14.7)	45 (31.5)	.05	5.98
	(2) undecided	52 (36.4)	11 (7.7)	41 (28.7)		
	(3) competent	25 (17.5)	2 (1.4)	23 (16.1)		

ASD, autism spectrum disorder; χ^2, chi-square test.

study is the first of its kind to exclusively include psychiatrists in the sample. Our findings revealed that participants perceived suicidal thoughts and behaviors to be less prevalent in individuals with ASD compared to those with typical development and other psychiatric disorders. Consistent with this finding, participants reported lower utilization of screening tools and expressed feelings of inadequacy in evaluating suicidal behavior in individuals with ASD. Interestingly, there were no significant differences in the results between research assistants and specialists.

While various studies have shown higher rates of suicidal ideation and behavior in individuals with ASD compared to the general population and other psychiatric disorders,[8,11,18-21] our participants' perceptions contrasted with these findings, suggesting limited knowledge or disregard of this issue among clinicians in our study. These results are consistent with similar findings in studies conducted with mental health professionals, including psychiatrists, psychologists, social workers, and pediatricians.[6,15] However, it is worth noting that all participants in our study were psychiatrists, highlighting the need to further examine these findings.

Possible reasons for this disparity include the tendency of clinicians to prioritize the core symptoms of autism while overlooking comorbid conditions. If suicidal behavior is not the primary reason for individuals with ASD seeking clinical care, clinicians may focus more on the current psychiatric symptoms. Additionally, it has been reported that suicidal behavior in individuals with ASD is more common among those with higher emotional intelligence skills and cognitive functioning.[19] The severity of core ASD symptoms in the individuals seen by the participating clinicians may have influenced these results.

In our study, clinicians reported using fewer screening scales to assess suicidal ideation and behavior in individuals with ASD. It is noteworthy that participants also utilized screening scales at a low rate for individuals without ASD. The use of screening scales in a clinical setting has been recommended as an intervention method to prevent suicidal behavior, which is a global public health concern.[22] Research suggests that clinicians who employ screening scales are more likely to identify suicidal ideation and behavior accurately.[23,24] The limited use of screening scales may contribute to clinicians failing to detect additional conditions, potentially due to the belief that the risk of suicide is not high in individuals with ASD. Difficulties in expressing feelings and thoughts, especially among individuals with ASD who exhibit moderate-to-severe symptoms, can be considered as factors hindering clinicians' assessment of suicide risk. The lack of focus or disregard for suicide risk in individuals with developmental disorders[25] and the inadequate development of tools to assess suicide risk in individuals with ASD are additional factors limiting clinicians' ability to address this issue. Studies have indicated that screening with validated tools is crucial for identifying suicidal behavior.[26] There is a need for research focused on developing screening tools specifically adapted for the Turkish population that can be used to assess suicide risk in individuals with ASD.

The competence of clinicians in assessing and managing a psychiatric disorder can be influenced by factors such as the number of patients they have examined, their experience conducting diagnostic interviews for the disorders, and their use of screening tools. During their specialization training, research assistants often acquire knowledge and skills related to ASD. However, it is surprising that there was no significant difference between specialists and residents in our study regarding questions about suicidal ideation and behavior in individuals with ASD. This finding may be attributed to the fact that most of our sample consisted of specialist doctors. Nonetheless, it highlights the need to prioritize training on suicidal behavior in ASD and consider ASD as a high-risk group for suicidal behavior. In a study conducted in a pediatric emergency unit, it was reported that increased training duration enhanced clinicians' self-confidence in

assessing suicidal ideation/behavior in individuals with ASD.[25] They also noted that increased self-confidence during the training period would contribute to appropriate interventions for these individuals. This result may be related to the limited use of screening tools for suicidal behavior in individuals with ASD in the literature and the insufficient evaluation of comorbidity in these individuals. Consistent with this, our participants reported using fewer screening tools for assessing suicidal behavior in individuals with ASD. Both training programs and future research should focus on increasing knowledge about the occurrence of suicidal thoughts and behaviors in individuals with ASD and developing tools and strategies for identifying risk in this population. It is essential to establish guidelines for intervening in suicidal behaviors in individuals with ASD. Furthermore, similar to previous studies, most participants in our study considered themselves inadequate in evaluating suicidal behavior in individuals with ASD.[6,25] Possible reasons for this finding include limited use of appropriate screening scales, insufficient emphasis on suicidal behavior in ASD during training, and the absence of guidelines for evaluating suicidal behavior in individuals with ASD.

Half of the participants in our study reported not utilizing the safety plan intervention when intervening in cases of suicidal behavior, with only 7 indicating its use specifically for individuals with ASD. This relatively low rate suggests a potential oversight of suicidal behavior, which can be comorbid and have severe consequences in individuals with ASD. In a study that included a sample that was not exclusively composed of psychiatrists, participants reported using the safety plan intervention at a rate of 21 for individuals with ASD.[6] Although there is limited research on the effectiveness and feasibility of the safety plan intervention in individuals with ASD, our study's findings align with the notion that suicidal behavior in this population may be overlooked. Additionally, the majority of participants expressed the need for adaptation of interventions for individuals with ASD, highlighting the necessity for further research in this area. Future studies should enhance our understanding of the occurrence of suicide in the ASD population and develop tools and strategies to identify risk across different clinical subgroups.[15]

In our study, compared to healthy individuals, general adult psychiatrists perceived suicidal behavior as more prevalent in individuals with autism than did child and adolescent psychiatrists. The potential reason for this discrepancy might be the varied presentations of suicidality in autism as perceived by clinicians specializing in children versus adults. During adolescence and adulthood, the increased prevalence of disorders associated with suicidal behavior (such as mood disorders and psychotic disorders) may lead general adult psychiatrists to observe more individuals displaying suicidal behavior. Upon examining the course of psychiatric disorders in individuals with autism transitioning from childhood to adulthood, it was found that ADHD (attention deficit hyperactivity disorders) symptoms declined with age. Anxiety symptoms began at a high level and remained consistent, while depressive symptoms varied, reaching a peak in young adulthood.[27] Considering this perspective, the higher prevalence of ADHD symptoms in childhood compared to adulthood, coupled with relatively lower depressive symptoms, might explain why child and adolescent psychiatrists report suicidal behavior less frequently. Another contributing factor could be the enhancement of cognitive abilities in individuals with autism as they age.[28] As cognitive skills improve, individuals with autism become more aware of their symptoms and the negative social situations they face. This heightened awareness can lead to self-stigmatization, which is more frequently observed in adulthood.[29] Many individuals with autism cope with social stigmatization. Over time, this leads to a negative self-perception and a detrimental view of their condition. In autism, self-stigmatization not only magnifies internalized symptoms and camouflaging behaviors but also independently elevates suicidal thoughts.[30,31] All these factors might account for the heightened observation of suicidal behavior in individuals with autism during adulthood. However, there is a need for more research to explore the differences in approach between child and adolescent and general adult psychiatrists, to understand the clinical manifestations of autism from childhood to adulthood, and to enhance awareness of suicidality, thereby improving training and intervention programs.

Our study has several limitations that should be acknowledged when interpreting the findings. First, the data collection process relied on an online survey, which may have introduced sampling biases and limited the generalizability of the findings. Additionally, since we did not gather information about the participants' working places, the extent to which our findings reflect the overall situation in the country is uncertain. Moreover, the use of self-report questionnaires may have been subject to response biases or recall inaccuracies. Another limitation is the lack of information regarding the participants' years of experience in the profession. This information could have provided valuable insights into the potential influence of professional experience on knowledge and attitudes toward suicidal behavior in individuals with ASD. Including this information in future studies would contribute to a more comprehensive understanding of the impact of professional experience on clinicians' perspectives in this area.

This study aimed to investigate the screening and intervention practices, as well as the thoughts of clinicians, regarding suicidal ideation and behavior in individuals with ASD. The findings highlight the importance of enhancing clinicians' knowledge about autism and suicidal behavior through educational initiatives. It is crucial to promote the use of screening scales and develop intervention options to address the specific needs of individuals with ASD who are at risk for suicidal behavior. Efforts should be directed toward recognizing the risk of suicide in this population and implementing appropriate preventive measures. Additionally, early diagnosis of ASD and the improvement of communication skills through early interventions can aid physicians in identifying and addressing the risks related to suicidal behavior in individuals with ASD.

Ethics Committee Approval: *This study was conducted at the Eskisehir Osmangazi University Medical School. Osmangazi University Noninvasive Clinical Researches Ethics Committee (Date: October 16, 2020, Approval No: 19).*

Informed Consent: *Written informed consent was obtained from the participants who agreed to take part in the study.*

Peer-review: *Externally peer-reviewed.*

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