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Autism and Assisted Suicide

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ABSTRACT

Autistic people have died by euthanasia and assisted suicide (EAS) in Belgium and the Netherlands. While these countries' laws allow EAS for patients suffering from nonterminal psychological disorders when certain "due care" criteria are met, the practice of granting EAS for psychological disorders in general has drawn scrutiny. But there are complex issues specific to autism that have received little attention. The author examines three important questions about the Belgian and Dutch due care criteria as they pertain to autism. First, how might autism affect decision-making capacity for EAS? Second, how might autism affect the voluntariness of EAS requests? Third, is autism a medically futile condition such that there is no reasonable alternative to EAS for alleviating suffering? The author argues that what is known about autism vis-à-vis these due care criteria suggests that autistic people might be a vulnerable group at heightened risk for irremediable harm of premature death from EAS.

KEYWORDS

Autism; autism spectrum disorders; ethics

1. Introduction

It is now well documented, if not well publicized, that autistic people have died by euthanasia and assisted suicide (EAS) in Belgium and the Netherlands.

In a recent study of assisted suicide involving individuals with intellectual disability and autism spectrum disorder (ASD) in the Netherlands, Tuffrey-Wijne, Curfs, Finlay, and Hollins (2018) presented three case reports from the Dutch Regional Euthanasia Review Committees (RTEs) describing individuals with diagnoses of ASD who died by assisted suicide between 2012 and 2016. I have found another RTE case from 2017 (2017-80) involving a woman diagnosed with pervasive developmental disorder not otherwise specified, which is also an ASD.¹

In a study of the databases of the Belgian Federal Control and Evaluation Committee on Euthanasia, Dierickx, Deliens, Cohen, and Chambaere (2017) examined cases involving psychiatric disorders and dementia between 2002

and 2013, and found seven cases in which individuals diagnosed with autism died by euthanasia during that period.

And in a study of 100 consecutive patients who requested EAS for psychological suffering at a psychiatric clinic in Belgium between 2007 and 2011, Thienpont et al. (2015) reported that seven patients had diagnoses of Asperger syndrome, another autism spectrum disorder, when they arrived at the clinic. Thirteen more patients were referred for further testing for ASD, and 12 of them received diagnoses of Asperger syndrome. So, 19 of the 100 patients were ultimately diagnosed with ASD, making ASD the third-most-common diagnosis in the study, behind major depressive disorder ($n=48$) and borderline personality disorder ($n=27$) but ahead of bipolar disorder ($n=10$), posttraumatic stress disorder ($n=13$), schizophrenia and other psychotic disorders ($n=14$), anxiety disorders ($n=11$), eating disorders ($n=10$), substance use disorders ($n=10$), and several other psychiatric disorders. In email correspondence with Dr. Thienpont (April 29, 2018), I have learned that 10 of these patients' requests for euthanasia were approved (two from the group that arrived with diagnoses of ASD and eight from the group referred for testing for ASD). And of these 10, eight ultimately died by euthanasia (two from the initial group of seven who arrived with diagnoses of ASD, and six from the group of 12 who were referred for autism testing). Note that 75% of those who died were not diagnosed with ASD until after they arrived at Thienpont's clinic, which was often within just a few months of their deaths by euthanasia. Both the rate of acceptance of euthanasia requests (52.6%) and the rate of death by euthanasia (42.1%) were higher for Thienpont et al.'s patients with ASD than were the rates for their overall sample, which were 48% and 35% respectively. The rates for patients who were diagnosed with ASD after arriving at the clinic as part of the EAS process were higher still with 66.7% of EAS requests approved and 50% of subjects dying by EAS. I return to this later.

While euthanasia and assisted suicide are legal in a number of countries (including Belgium, the Netherlands, Luxembourg, Switzerland, Colombia, and Canada), as well as in a number of jurisdictions in the United States (including Oregon, Washington, California, Colorado, Montana, Vermont, Hawaii, and Washington, DC), most of the jurisdictions that have legalized EAS do not permit it for individuals whose suffering is caused by nonterminal conditions, including psychiatric or psychological disorders (Dyer, White, & Garcia Rada, 2015; Kim & Lemmens, 2016; Schiltz, 2018). However, both the Belgian Act on Euthanasia of May 28th, 2002 and the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002 allow EAS for patients suffering from psychiatric or psychological disorders when certain "due care" criteria are met. And

while the conditions laid down in these two acts are not identical, there are certain common criteria that must be met for EAS to be legal in both jurisdictions.² First, individuals seeking EAS must be legally competent (i.e., they must have the capacity to make this particular decision).³ Second, they must make a request that is voluntary and well-considered. And third, the individual must be suffering unbearably (in a way that is “palpable” to the physician)⁴ from a condition that is medically futile such that there is no reasonable alternative to EAS for alleviating the person’s suffering.⁵ These due care criteria have been put in place by the Belgians and the Dutch to protect vulnerable individuals from the irremediable harm of premature death; if any of the criteria are not met, then administering EAS becomes ethically and legally problematic on the Dutch and Belgians’ own terms.

The practice of granting access to EAS for psychological or psychiatric disorders in general has, of course, drawn a fair bit of scrutiny (e.g., Kim, De Vries, & Peteet, 2016; Kim & Lemmens, 2016; Kim et al., 2016; T. Lemmens, 2018; T. Lemmens, Kim, & Kurz, 2018; W. Lemmens, 2017; Rooney, Schuklenk, & van de Vathorst, 2018). Even Belgian and Dutch authorities acknowledge the need to proceed with great caution in cases involving mental illness or intellectual disability (e.g., RTE cases 2017-26, 2014-59, 2018-32, 2018-02; Verhofstadt, Thienpont, & Peters, 2017) and to consult with experts in cases involving psychiatric or psychological disorders (Belgian Act on Euthanasia, II.3.3.1; Dutch RTE Code of Practice, ch. 3.2, 12). However, there are complex issues specific to autism that have received very little attention in scholarly discussions of EAS. In particular, there are important questions that need to be asked about the due care criteria noted previously as they relate to autism. In this article, I examine three of those questions. First, how might autism affect decision-making capacity for EAS? Second, how might autism affect the voluntariness of an EAS request? And third, is autism indeed a medically futile condition such that there is no reasonable alternative to EAS for alleviating suffering? While there is still a great deal we do not know about autism vis-à-vis these due care criteria for EAS, I will argue that what we do know suggests that autistic people might be a vulnerable group at heightened risk for irremediable harm of premature death from EAS. What is more, despite the fact that the Belgian Act requires and the Dutch Code of Practice recommends proceeding with great caution and consulting experts in cases involving psychological disorders, there is little evidence that the nuances of autism are being adequately taken into account in EAS cases involving people on the spectrum. All of this raises serious questions about whether the due care criteria the Dutch and Belgians themselves put in place for EAS to be ethical and legal have been sufficiently observed to protect autistic people from the harm of premature death. I conclude, therefore, with

recommendations for further research and more stringent enforcement of laws and ethical standards. Until we possess more research on the nuances of autism vis-à-vis the due care criteria for EAS, though, and until measures are fully in place to ensure that expertise in autism is adequately brought to bear in EAS cases involving people on the spectrum, I believe it would be prudent to err on the side of caution and consider autistic people to be a vulnerable group at heightened risk for harm of premature death from EAS.

2. Decision-Making Capacity

For EAS to be ethical and legal, patients must be legally competent and have the capacity to make this particular decision. Unfortunately, we know relatively little about the decision making of people on the spectrum (Mussey, Travers, Klinger, & Klinger, 2015), and even less about their capacity to make decisions specifically about EAS. In fact, I am not aware of a single study that examines this particular dimension of autistic decision making directly. That fact alone should give us pause since EAS is a grave act that cannot be undone. More problematically, though, the things we do know about autistic people's decision making in general raise concerns about their decision-making capacity for EAS.

Luke, Clare, Ring, Redley, and Watson (2012) stated that the collective evidence of the few studies that have been done on decision making in people with ASD suggest that “the decision-making of adults with ASCs [autism spectrum conditions] may differ from that of the neurotypical population” (p. 614); that their tendency to rely on rules might interfere with autistic people making decisions; that stigma also appears to influence their decision making (p. 614); that adults with ASD more often perceive their conditions as “interfering with, rather than enhancing, decision-making” (p. 617); and that as scores for anxiety and depression increased for these individuals, “the perceived frequency of interference from ASCs also increased” (p. 617).⁶ This last point is particularly important because anxiety and depression are risk factors for suicidality in people on the spectrum (Cassidy et al., 2014; Mayes, Gorman, Hillwig-Garcia, & Syed, 2013; Storch et al., 2013); if increases in anxiety and depression also lead to greater interference with decision making, there might be a perfect storm brewing for autistic people experiencing co-occurring anxiety or depression while making decisions about EAS. All of this led Luke et al. to conclude that their own “findings suggest that, compared with neurotypical individuals, intellectually able people with ASCs experience greater difficulty with decision-making” (Luke, Clare, Ring, Redley, & Watson, 2012, p. 618). Of course, the mere fact that autistic people might make decisions differently

or even have difficulty making decisions does not necessarily mean that they lack decision-making capacity for EAS. How, then, can we begin to tackle the question of whether autism might affect decision-making capacity in EAS cases?

The most widely accepted standards for assessing decision-making capacity are the Appelbaum criteria, which include “the abilities to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices” (Appelbaum, 2007, p. 1835). It has been observed, though, that these criteria are primarily cognitive (Charland, 1998; Kluge, 2005; Mackenzie & Watts, 2011), and various scholars have suggested that they are not sufficient to capture everything involved in decision-making capacity.

According to Eckstein and Kim (2017),

A person may be able to comprehend and believe that a harm would in fact occur to him or her without the treatment. But that does not automatically translate into a decision to accept the treatment. The person’s ability to incorporate one’s motives or *values* into the decision must also be intact. . . . this ability is distinct from the ability to form adequate beliefs (appreciation). If for some reason the person is incapable of being motivated to avoid the harm at issue, then he or she may not have DMC [decision-making capacity]. (p. 684, italics added)

There is, thus, a valuational component to decision-making capacity.

Some scholars have also argued for a more important role of emotions in decision-making capacity (Charland, 1998; Kluge, 2005; cf. De Martino, Harrison, Knafo, Bird, & Dolan, 2008; Eckstein & Kim, 2017; Kim, 2015). For example, Kluge (2005) proposed that decision-making capacity has three necessary components: cognitive, valuational, and emotional competence. And Charland presented a compelling, integrated model for decision-making capacity in which emotions give rise to values, and values drive appreciation, which is one of the cognitive dimensions of decision making.

As it turns out, studies have shown that people with ASD exhibit differences, and often impairments, in all three areas of decision-making capacity (i.e., the cognitive, valuational, and emotional).

People with ASD, especially “high-functioning” ASD, often have, or appear to have, intact cognitive capacities (i.e., capacities for logical/analytic thinking). But the DSM-5 indicates that the intellectual profiles of people with ASD are complicated, with uneven abilities and gaps between measured IQ and adaptive skills often observed (American Psychiatric Association, 2013). And studies have produced evidence of impairments in autistic people across a wide range of cognitive domains that affect decision making, including adaptive function (Hill, Gray, Kamps, & Varela, 2015;

Tomanik, Pearson, Loveland, Lane, & Shaw, 2007),⁷ executive function (including planning, mental flexibility, working memory, and perhaps some types of inhibition) (Demetriou et al., 2018; Geurts, De Vries, & Van den Bergh, 2014; Hill, 2004; Luke et al., 2012; Storch et al., 2013; Wallace et al., 2016),⁸ and the ability to learn which decisions are advantageous and which are disadvantageous (Mussey et al., 2015).

Interestingly, Levin et al. (2015) concluded that “decisions that normally rely on *affect* or intuition may be more difficult for individuals with ASD to make than decisions that rely on deliberative and logical thinking” (p. 8, italics added; cf. Reyna & Brainerd, 2011). Zhang et al. (2015) found that autistic subjects had impairments in decision making under ambiguity and under risk, and suggested that poor decision making in autistic subjects might correlate with impairment in emotional processing of feedback in terms of gains and losses. Thus, both Levin et al. and Zhang et al. suggested that deficits in decision making among people with ASD might be related to difficulties with affect or emotion.⁹

Consistent with these suggestions, there is evidence that people with ASD process emotions differently from neurotypicals. In particular, there have been a number of studies that have found emotional dysregulation in people on the spectrum (Samson, Wells, Phillips, Hardan, & Gross, 2015). For example, Richey et al. (2015) found decreased brain capacities for upregulating and downregulating emotion in autistic subjects compared with their control group. Nuske et al. (2017) indicated that children with ASD are at much higher risk for emotional regulation problems than are typically developing peers and that difficulty regulating negative emotions in individuals with ASD has been found to “impact their behavioral and mental health” (p. 1808); in particular, Nuske et al. noted an association between maladaptive and avoidant (emotional regulation) strategies in adolescents with ASD and depression, anxiety, and problem behavior. Thomson, Riosa, and Weiss (2015) also reported a relationship between emotional regulation problems in children with ASD and depression (see also Barnhill et al., 2000; Zablotsky, Bradshaw, Anderson, & Law, 2013). The connection between emotional regulation and depression is especially important because, as noted previously, depression has been linked to increased suicidality for people on the spectrum.

Given the relationship between emotions and valuing, and given common differences in the emotion processing profiles of people on the spectrum, it is not surprising that studies have also identified differences between autistic people and neurotypicals in various dimensions of valuation. Spikins, Wright, and Scott (2018) found that individuals with high autism spectrum questionnaire scores tended to value objects that have practical function (e.g., laptops) more highly than objects that have

sentimental value or reminders of relationships (e.g., pictures of loved ones), whereas neurotypical subjects were more likely to value objects with purely sentimental value. Wang, DiNicola, Heymann, Hampson, and Chawarska (2018) found that children with ASD performed just as well as typically developing controls on nonsocial value learning tasks (valuing objects rather than people) but performed less well on social value learning tasks (selecting faces or the most relevant parts of faces). At a more neurological level, Kohls et al. (2013) found reduced activation of reward centers of the brain when autistic subjects were exposed to both social and monetary rewards, and Dichter et al. (2012) found reduced activation of reward centers of the brain when autistic subjects were exposed to monetary rewards but not when they were exposed to “ASD-relevant” objects such as trains or electronic devices. These studies clearly suggest differences in valuing between autistic and neurotypical people. Of course, differences are not always deficits; but we must nevertheless ask whether, in some instances, these differences might compromise valuational capacities.

To tie all of this together, while we still know relatively little about autistic decision making as it pertains to EAS specifically, the collective evidence of studies of autism and decision making in general gives cause for concern. If decision-making capacity has cognitive, valuational, and emotional components, and if individuals with ASD often manifest differences and even impairments in all of these domains, we must consider the possibility that impairments in these dimensions of decision making might affect the EAS requests of autistic people. What is more, the case files of the Dutch euthanasia review committees give evidence that these are not just speculative concerns: of the four RTE cases involving people with autism spectrum disorders, three report symptoms that suggest problems with emotional regulation (2013-21, 2014-77, 2017-80) and all four report symptoms that suggest problems with executive function.¹⁰ And yet, the case files contain no explicit consideration of whether or how these factors might impact decision-making capacity in these individuals. Nor is there evidence that experts in autism who might better understand the complex cognitive, valuational, and emotional profiles of people on the spectrum and recognize their possible implications for decision-making capacity have been consulted in these cases—despite the fact that this kind of consultation is recommended by the Dutch RTE Code of Practice (ch. 3.2). This raises serious questions about whether, or to what extent, the due care criteria for assessing decision-making capacity are really being met in these cases.

Now, to be clear, I do not mean to suggest that merely having a diagnosis of ASD renders an individual incompetent for decision making in this area. Each individual must be assessed for decision-making capacity functionally and not simply on the basis of her diagnoses. But given what we

know about differences, and in some cases deficits, in how people with ASD cognize, value, and experience emotion—as well as how much we do not know about how people with ASD function in these areas—I do want to suggest that every EAS request from a person with ASD should, at minimum, be scrutinized very carefully for decision-making capacity with special attention to the cognitive, valuational, and emotional complexities of autism. These are complicated cases. In fact, Thienpont et al. (2015) pointed out that the complexity of psychiatric disorders might have led to the underdiagnosis of ASD in their group. If ASD is complex enough to have gone undiagnosed in their EAS patients at a very high rate, though, might it not also be complex enough for clinicians to underappreciate its effects on the decision-making capacity of autistic people requesting EAS? Just as there might be individuals with intellectual disabilities who are nevertheless competent to make decisions about EAS, so, too, there might be individuals who do not have intellectual disabilities—for example, people with depression or anorexia—who do not have decision-making capacity in this specific area (Kim, 2015; Tuffrey-Wijne et al., 2018). And some people with autism might fall into this latter category: they might present clinically as intellectually competent, but there might in fact be “splinter” deficits in cognitive and executive functioning, emotional processing, or valuation that would impair their capacities to make this particular decision. And yet, despite the fact that reports from both Belgium and the Netherlands often acknowledge the need to proceed with great caution in cases involving either mental illness or intellectual disability (e.g., RTE cases 2014-59, 2017-26, 2018-02, and 2018-32; Verhofstadt et al., 2017), I see little evidence of this heightened level of caution or attention to the nuances of autism in either the case reports or the scholarly studies of cases involving individuals on the spectrum (cf. Dierickx et al., 2017; Doernberg, Peteet, & Kim, 2016; Kim & Lemmens, 2016; Tuffrey-Wijne et al., 2018).

3. Voluntariness

A second requirement for EAS requests that is common across jurisdictions is the condition that the request must be voluntary and well-considered. This requirement is not entirely separate from issues of decision-making capacity: for example, a request cannot truly be well-considered if the person making it cannot understand or reason about the facts of the matter. According to Doernberg et al. (2016), the Netherlands’ requirement of a “voluntary and well-considered” request “is interpreted to contain a requirement of intact capacity” by the Dutch RTE (p. 557). And discussions of decision-making capacity—especially the element of value—also broach the subject of voluntariness (e.g., Kim, [2015] noted that there is a

motivational element of value and Charland [1998] noted that emotions move us to act). But there are other issues pertaining to the voluntariness of EAS requests that need to be examined in greater detail.¹¹

It is widely acknowledged that EAS requests involving depression need to be scrutinized very carefully because the request for death can be a symptom of the disorder (e.g., Doernberg et al., 2016; Levene & Parker, 2011; Verhofstadt et al., 2017; RTE cases 2013-11, 2014-01, 2018-13).¹² And this can be true of psychiatric disorders other than depression as well (Thienpont et al., 2015; Verhofstadt et al., 2017). I take it that the fundamental problem in these cases is that the individual is not making a voluntary request—that is, she is not *freely* requesting death—but is rather *caused* to desire death by the disorder itself, which is, in some sense, extrinsic to her free will.¹³ And while the distinction might be a subtle one, this is different from making a free request to die *in response to* the suffering caused by a disorder, whether that disorder be physical or psychological. Now, I would propose that we need to consider the possibility that autism could put people at greater risk for psychological forces that would compromise the voluntariness of an EAS request.

In some cases, co-occurring depression might impact the voluntariness of an EAS request from a person on the spectrum. Stewart, Barnard, Pearson, Hasan, and O'Brien (2006) stated that diagnosis of depression co-occurring with autism can be difficult, though, because there are shared core symptoms (e.g., social withdrawal), because barriers to communication might mask symptoms and make assessment more difficult, because onset of depression can manifest as an increase in symptoms of ASD such as obsessiveness and self-injury, and because the characteristics of ASD can affect the expression of depressive symptoms (as in the case of the autistic man who became incontinent with urine when depressed, or another who lost bowel and bladder control when depressed, or with others who become more aggressive or self-injurious during episodes of depression; see also Ghaziuddin, Ghaziuddin, & Greden, 2002). In some instances, Stewart et al. noted, depression might even present as an improvement in “autistic” behaviors, such as in cases where a depressed individual becomes less interested in restricted interests or repetitive behaviors (see also Ghaziuddin et al., 2002). Given the difficulty of diagnosing depression in autistic people, and given that depression often causes suicidality, there is reason to be concerned that people on the spectrum might be at heightened risk for requesting EAS because of undiagnosed depression rather than from a fully voluntary choice.

Despite the difficulty of diagnosing depression co-occurring with autism, numerous studies have indeed identified a high co-occurrence of autism and depression (e.g., Ghaziuddin et al., 2002; Hurtig et al., 2009; Kim,

Szatmari, Bryson, Streiner, & Wilson, 2000; Wing, 1981). In fact, studies have suggested that anywhere from 30% to more than 50% of people with ASD experience co-occurring depression during their lifetimes (e.g., Ghaziuddin, Weidmer-Mikhail, & Ghaziuddin, 1998; Hedley, Uljarević, Wilmot, Richdale, & Dissanayake, 2017, 2018; Hofvander et al., 2009; Sterling, Dawson, Estes, & Greenson, 2008). For sake of comparison, a 2017 meta-analysis of data from studies of depression from 30 countries indicated a lifetime prevalence of 10.8% for the general population (Lim et al., 2018).¹⁴ This suggests that people on the spectrum are at significantly higher risk for depression than the general population. Interestingly, it has also been found that autistic individuals with less social and communication impairment and higher cognitive abilities are at greater risk for depression (Ghaziuddin et al., 2002; Kim et al., 2000; Sterling et al., 2008).¹⁵ Barnhill et al. (2000) reported that: “Attwood (1998) hypothesized that for adolescents with Asperger Syndrome, awareness of their social difficulties may lead to anxiety, confusion, and despair” (p. 150). I should note here that autistic people who can legally request EAS are more likely to be “higher-functioning,” and are therefore at higher risk for depression.

Of course, for purposes of this article, depression is important primarily because the disorder itself can cause suicidality, and suicidality can diminish the voluntariness of a request for death. As recently as 2013, Mayes et al. observed that “Although depression is common in autism, almost no research is available on suicide ideation and attempts” (p. 109). However, we have learned some things about autism and suicidality in the last few years. People on the spectrum present with much higher levels of suicidal ideation than does the general population (Hedley et al., 2017, 2018; Raja, Azzoni, & Frustaci, 2011). In a study of suicidality in people with Asperger syndrome, Cassidy et al. (2014) found that the lifetime experience of suicidal ideation was 66%, which they report to be nine times higher than the general population in England (p. 145).¹⁶ In a study of Swedish medical records, Hirvikoski et al. (2016) found that autistic people were 7.55 times more likely to die by suicide than the general population. In fact, suicide accounts for 14% of deaths in autistic adults who do not have intellectual disability (Hirvikoski et al., 2016; Mandell, 2018). As with depression, autistic people who do not have intellectual disability are at significantly higher risk of death by suicide than autistic people who do have intellectual disability (Hirvikoski et al., 2016).¹⁷ According to Hirvikoski et al., females with ASD are 13 times more likely to die by suicide than are females in the control group. Moses (2018) found that youths with ASD were six times more likely to report having made at least one suicide attempt in the last 12 months than were youths without disabilities, were more likely to have made multiple suicide attempts than youths without disabilities, were more

likely to report having made multiple suicide attempts than just a single attempt, and indeed were more likely to report having made multiple suicide attempts than youths with any other disability (see also Mandell, 2018). Mayes et al. (2013) reported that children with autism were 28 times more likely to have suicidal ideation or attempts than were typically developing children (according to reports by their mothers).¹⁸ They also found that teasing was one of the comorbid psychological problems most highly associated with suicidality, with suicidal ideation or attempts being three times more common in children with ASD who were teased than in those who were not (Mayes et al., 2013). Hedley et al. (2018) found that ASD traits correlate with loneliness and proposed a discrete mechanism in which loneliness, mediated by depression, contributes to thoughts of self-harm in adults with ASD. Finally, Mayes et al. found that suicidal ideation correlated with anxiety in children on the spectrum and that depression, unsurprisingly, was “the strongest single predictor of suicide ideation or attempts in children with autism” (p. 115; see also Cassidy et al., 2014; Storch et al., 2013).

It is important to note that while individuals with ASD and depression have very high rates of suicidality, many autistic people who do not have depression also report suicidal ideation and attempts. In fact, Cassidy et al. (2014) found that the lifetime rates of suicidal ideation (66%) were more than double the lifetime rates of depression (31%) among their subjects with Asperger syndrome, which led them to speculate that there might be a different process for suicidal ideation in Asperger syndrome than in other clinical groups (see also Hedley et al., 2018; Raja, 2014). In other words, Cassidy et al.’s data could suggest that the high levels of suicidality found among people on the spectrum are not attributable solely to co-occurring depression.¹⁹ This is a crucial finding: autism itself, or something in the social conditions of autism, might be giving rise to higher rates of suicidality, even when there is no co-occurring depression.

Intriguingly, Cassidy et al. (2014) also speculated that the late diagnosis of Asperger syndrome in their cohort (mean age = 31 years) might have contributed to the high rates of suicidal ideation, noting that many of these individuals had difficulties such as social exclusion, unfulfilled educational potential, difficulties with getting or keeping a job or being promoted, and difficulties with developing close relationships, which could have been exacerbated by lack of appropriate support throughout their lives; and they concluded by suggesting that “Delayed diagnosis in adulthood could possibly be another risk factor for suicidal ideation and plans or attempts in people with Asperger’s syndrome” (p. 146). Recall that 12 of Thienpont et al.’s (2015) patients did not receive their ASD diagnoses until they were referred for further testing as part of the EAS process, and that six of those

12 died by euthanasia, giving these people a significantly higher rate of death by EAS than other subjects in the study. In light of Cassidy et al.'s suggestion that late diagnosis of ASD might be a risk factor for suicidality, it is worth asking whether these individuals might have been at elevated risk for suicidality because of their late diagnoses, and might therefore have been especially vulnerable to harm from euthanasia, even relative to other people on the spectrum.

Given the findings that people with ASD are at significantly higher risk for depression and suicidality, it is entirely unsurprising that many researchers recommend screening children, adolescents, and adults on the spectrum for both depression and suicidality (Cassidy et al., 2014; Ghaziuddin et al., 1998; Mayes et al., 2013; Raja, 2014; Segers & Rawana, 2014; Sterling et al., 2008; Storch et al., 2013).

To be sure, we need much more study of suicidal ideation and attempts in the lives of people with ASD (Cassidy et al., 2014; Hedley et al., 2017; Hofvander et al., 2009; Raja, 2014). But if depression and suicidality can limit the voluntariness of a request for death, what are the implications of the difficulties in diagnosing depression co-occurring with autism? More disconcertingly, what are the implications of the high levels of depression and suicidality already known to exist among people with ASD? Mustn't we at least consider the possibilities that depression could easily be going undiagnosed in people on the spectrum who request EAS and that there might be a heightened risk for the voluntariness of EAS requests from autistic people to be compromised by depression or suicidality? And once again, these are not merely speculative concerns. In the four Dutch RTE case files involving patients with ASD, one person is described as having "severe and probably chronic" depression (2013-21, trans. Tuffrey-Wijne et al., 2018, p. 5), one is described as suffering from "continuous . . . suicidal thoughts" (2017-80), and one is described as having made multiple suicide attempts from an early age (2014-17). Yet, the case files provide no evidence of serious consideration of the possibility that the voluntariness of these requests might have been compromised. Instead, each simply states, using boilerplate language, that a "voluntary and well-considered request" was made—sometimes within just a few lines of noting the patient's depression (2013-21) or autism (2016-48).

4. Incurable Suffering

Finally, let me turn to the question of whether the condition of autistic people is medically futile or incurable such that there is no prospect of improvement and no reasonable alternative to EAS for alleviating their suffering. Because it is true that ASD as such is not generally regarded as

“curable,” I will focus on the issue of whether there is no reasonable alternative to EAS for alleviating the suffering of autistic people.

To the best of my knowledge, there is no systematic study of either the qualities or the severity of suffering that people on the spectrum experience from their autism.²⁰ In the Dutch RTE case files involving autistic people, though, we find one report of physical suffering as a result of sensory hypersensitivity (2017-80). Three case files report suffering arising from problems with emotional regulation (2013-21, 2014-77, 2017-80). And all four case files report suffering arising from problems with executive function.²¹

The most striking feature of the accounts of suffering in the Dutch case files, however, is the reports of what we might describe as social, interpersonal, or relational suffering. For example, in case 2017-80, we read that a young woman with pervasive developmental disorder not otherwise specified “could not enter into friendships and had become isolated, even within her own family.” In case 2016-48, we are told that an elderly woman with ASD “no longer had any interest in the world around her and was no longer able to form social contact. She was avoidant of care and contact. The patient spent her days in isolation in her room” (trans. Tuffrey-Wijne et al., 2018, p. 11). In case 2013-21, we read that an older gentleman who was self-diagnosed with Asperger’s “was an utterly lonely man He quarreled with everyone who wasn’t a support professional. The patient had become totally stuck in isolation and found this increasingly painful” (trans. Tuffrey-Wijne et al., 2018, p. 5). And in case 2014-77, we are told that a younger man with Asperger syndrome:

suffered from the fact that he had a great need for closeness with others whilst he couldn’t maintain long-lasting social contacts. . . . He suffered from his continuous yearning for meaningful relationships and his repeated frustrations in this area, because of his inability to deal adequately with closeness and social contacts. (trans. Tuffrey-Wijne et al., 2018, pp. 7–8)

Note that every one of the four Dutch RTE cases dealing with a person on the spectrum identifies loneliness, isolation, or a frustrated desire for relationships as a component of the patient’s suffering (cf. Verhofstadt et al., 2017).

These accounts of social suffering are heartbreaking, but not entirely surprising. Impairments in social interactions and social communication are at the core of autism (American Psychiatric Association, 2013). And studies show that people on the spectrum are at elevated risk for loneliness and isolation, which are predictors of depression and suicidality (Hedley et al., 2018; Hirvikoski et al., 2016; Mazurek, 2014; Moses, 2018; Segers & Rawana, 2014; Van Orden, Merrill, & Joiner, 2005). So, it is small wonder that loneliness and isolation should feature prominently in the suffering of autistic people seeking death.

The social suffering of people on the spectrum is, of course, complex. It can arise, to some extent, from deficits in social communication and social interactions in autistic people themselves. However, it can also be caused directly by other people, as in instances of bullying and teasing, which are common for people on the spectrum and are predictors of both depression and suicidality. Klomek, Marrocco, Kleinman, Schonfeld, and Gould (2007) found that frequent exposure to bullying was related to high risks for depression, suicidal ideation and attempts. Hofvander et al. (2009) reported that 56% of their subjects with ASD were bullied in school, with this victimization being most common among their female subjects. Mayes et al. (2013) found teasing to be a predictor of suicidal ideation and attempts for children on the spectrum. Segers and Rawana (2014) noted that peer victimization occurs in a larger percentage of individuals with ASD, that it is anecdotally reported to be a trigger for suicide, and that social impairment is a significant contributor to difficulties experienced by people with ASD. Segers and Rawana also stated that:

individuals with ASD may be particularly vulnerable to suicidal thoughts and behaviors because of characteristics related to the disorder itself and its social implications (e.g., isolation, difficulties communicating with others, peer victimization). (p. 516)

And Botha and Frost (2018) suggested that negative social factors including stigma, discrimination, victimization, bullying, isolation, and rejection must be regarded as significant contributors to the psychological distress of people on the spectrum (see also Hatzenbuehler, Phelan, & Link, 2013).

Without wanting to diminish the significance of the impairments or the very real challenges autistic people have in forming satisfying relationships, it seems to me that this is a situation that cries out for analysis in terms of the social model of disability. The social model of disability suggests that disabilities do not arise primarily from biological or psychological impairments so much as from disabling conditions created by society. And while I do not think the social model is adequate to explain the full range of disabilities, I do think that, in the case at hand, it has something very important to offer. After all, relationships are, by nature, two-way streets. And at least some of the difficulties autistic people experience in forming relationships result from the ways in which neurotypical individuals respond to autistic people. So, the suffering caused by these difficulties can also be affected by altering the ways that neurotypicals relate to autistic people. For example, if we could eliminate bullying and teasing, if we could develop understanding and acceptance of social and communicative differences, and if we could foster inclusion and friendships between neurotypical people and people on the spectrum, these simple actions could fundamentally alter the social disability and suffering many autistic people experience. In

the extreme cases we encounter in euthanasia and assisted suicide records, they might even be lifesaving measures.

These are not, by the way, just the musings of a philosopher: we can find similar recommendations coming from the scientific community (Hedley et al., 2017; Mazurek, 2014). According to Schiltz et al. (2018):

Evidence suggests strong links between social difficulties, friendships, and depression in ASD, [sic] thus, *interventions aimed at increasing social skills and, in turn, cultivating friendships, have the potential to ameliorate symptoms of depression.* (p. 835, italics added)

Botha and Frost (2018) suggested that:

autistic individuals experience an added stress burden in the form of minority stress. *This stress burden is a potentially preventable factor in the mental health and wellbeing disparity seen in the autistic population.* Minority stressors such as victimisation and discrimination, everyday discrimination, expectation of rejection, outness, internalised stigma, and physical concealment of autism consistently predicted diminished wellbeing and heightened psychological distress. (p. 9, italics added)

And Hedley et al. (2018) concluded that:

The identification of loneliness as a factor associated with depression and thoughts of self-harm as a screener for suicidal ideation in this study points to potentially useful treatment options. *Programs that combat loneliness or [promote] inclusion may provide benefits in terms of mental health and well-being.* (p. 6, italics added)

Indeed, in some cases, they might be the difference between life and death!

Beyond this, though, it is important to note that there is less reason every day to despair that autism is a “futile” condition such that there is no reasonable alternative to EAS for alleviating patients’ suffering. The number of evidence-based interventions that can effectively address the core impairments of autism has grown steadily over the past few decades (e.g., Wong et al., 2015). And there are interventions that specifically address problems that recur thematically in the accounts of the suffering of autistic EAS patients, including programs for improving emotional regulation (Thomson, Riosa, & Weiss, 2015) and executive functions such as planning, problem solving, and flexibility (Kenworthy et al., 2014; see also Wallace et al., 2016). What is more, while we once tended to think that autism interventions were only effective for a brief developmental window during childhood, there is now evidence that interventions can be effective into adolescence and even adulthood (e.g., Bishop-Fitzpatrick, Minshew, & Eack, 2014; Palmen, Didden, & Lang, 2012; Walton & Ingersoll, 2013). Crucially, there are now evidence-based interventions for adults on the spectrum that target social skills (Laugeson, Gantman, Kapp, Orenski, & Ellingsen, 2015; Walsh, Holloway, & Lydon, 2018) and the symptoms of anxiety and depression (Sizoo & Kuiper, 2017; Spek, van Ham, & Nyklíček,

2013; Spain, Sin, Chalder, Murphy, & Happé, 2015). In fact, there is now evidence that interventions that develop social skills in people with ASD might themselves ameliorate symptoms of depression and suicidality (Hillier, Fish, Siegel, & Beversdorf, 2011; Schiltz et al., 2018). These interventions offer new hope of overcoming the devastating isolation and loneliness that are so prominent in the suffering of autistic people who request EAS.

Now, inasmuch as the due care criteria require that the patient's condition be medically futile such that there is no prospect of improvement and no reasonable alternative to EAS for alleviating her suffering, we must ask whether these autism interventions have really been given a fair trial. Unfortunately, the answers we get from the Dutch case files and the Belgian reports are not reassuring. Only one of the four Dutch RTE case reports even mentions autism interventions—and it does so quite vaguely. And in Thienpont et al.'s Belgian studies, we find that there are individuals not being diagnosed with ASD until they are well into the euthanasia process, sometimes just a few months before their deaths. Since most autism interventions require months or years to be effective, one wonders whether it is even possible that these interventions could have been tried in any serious way and, thus, whether the due care criterion that there be no reasonable alternative to EAS for alleviating the patient's suffering was really observed.

5. Conclusion

As noted previously, the Dutch and Belgian due care criteria require that individuals requesting EAS have decision-making capacity, make a voluntary request, and suffer from a condition that is medically futile such that there is no reasonable alternative to EAS for alleviating the patient's suffering. These due care criteria were put in place to protect vulnerable people from the irremediable harm of premature death. And while there is still much we do not know about autism vis-à-vis these due care criteria, what we do know gives cause for concern. First, we know that cognitive, emotional, and valuational impairments can affect decision-making capacity; we know that people on the spectrum commonly exhibit impairments in all of these areas; and we know that the Dutch RTE files provide evidence that actual autistic people whose lives have been ended by EAS exhibited traits that appear to reflect impairments in these areas. Second, we know that depression and especially suicidality can diminish the voluntariness with which a request for death is made; we know that people with autism are at exceptionally high risk for both depression and suicidality; and we know that autistic people whose lives have been ended by EAS exhibited

symptoms of both depression and suicidality. Finally, we also know that while autism can sometimes cause tremendous suffering in the lives of people on the spectrum, there are interventions that can address the symptoms that cause many kinds of their suffering, and in fact something as simple as the way that neurotypicals respond to autistic people can be a powerful means of alleviating two of the most profound types of suffering that autistic people experience: loneliness and isolation. But the Dutch case files give very little evidence that these interventions are being employed, and the Belgian studies raise doubts about whether it is even possible that they could have been employed because of late diagnoses of autism and the time required for autism interventions to be effective. All of this suggests that autistic people might be a vulnerable group at heightened risk of premature death from EAS due to impairments in decision making, diminished voluntariness, and under-utilization of interventions, and that these very impediments were evident in cases in which autistic people have died by EAS. Beyond this, despite the fact the Belgian Act requires and the Dutch Code of Practice recommends proceeding with great caution and consulting experts in cases involving psychological disorders, there is alarmingly little evidence that the nuances of autism are being adequately taken into account when assessing the due care criteria in these cases or that experts in autism are being consulted in EAS cases involving people on the spectrum. As things stand, then, there are reasons to be seriously concerned about whether the due care criteria are being strictly observed in cases in which people on the spectrum have died by EAS and, therefore, whether these cases meet the ethical and legal standards the Dutch and Belgians have themselves established to protect vulnerable people from the harm of premature death by EAS.

Providing EAS for autistic patients is a controversial practice, and neither the practice nor the controversy is likely to end anytime soon. To advance the debate about this issue, we need more research on ways in which autism might affect decision making for EAS, including studies of autistic people's cognition (with particular attention to executive function and adaptive skills) as well as their emotion and valuation. We also need more research on depression and suicidality in autistic people, and ways in which they might affect the voluntariness of EAS requests. And we need more research on autism interventions that can effectively address the symptoms and suffering that lead autistic people to request EAS. In addition, to meet their own ethical and legal standards, Dutch and Belgian officials need to do more to ensure that physicians, psychiatrists and other clinicians involved in the EAS process are fully educated in the nuances of autism as they pertain to EAS; they also need to enforce much more stringently the existing legal and ethical requirements for exercising great caution and consulting

with experts in cases like these by insisting that autism specialists be involved in cases in which autistic people request EAS. Until we possess more research on the nuances of autism vis-à-vis the due care criteria for EAS, though, and until measures are fully in place to ensure that expertise in autism is adequately brought to bear in EAS cases involving people on the spectrum, it would be prudent to err on the side of caution and consider autistic people to be a vulnerable group at heightened risk for harm of premature death from EAS.

Notes

1. The Dutch RTEs publish annual reports containing general information about all EAS cases in a given year, and post selected case files in a database on the RTE website. As the RTEs do not post all of their case files online, though, we cannot infer anything about the frequency with which autistic people have died by assisted suicide in the Netherlands from the online files. New files involving individuals with ASD have been posted since the initial writing of this article, and will be addressed in a future update.
2. According to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002, “the requirements of due care . . . mean that the physician: a) holds the conviction that the request by the patient was *voluntary and well-considered*, b) holds the conviction that the patient’s *suffering* was lasting and unbearable, c) has informed the patient about the situation he was in and about his prospects, d) [the physician] and the patient hold the conviction that there was *no other reasonable solution* for the situation he was in, e) has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a–d, and f) has terminated a life or assisted in a suicide with due care” (Ch. II, article 2, section 1, italics added). The Dutch RTE *Code of Practice* presents an alternate translation of the relevant section of the Dutch Act, but the substance of the requirements is the same: “In order to comply with the due care criteria referred to in . . . the Criminal Code, the physician must: a. be satisfied that the patient’s request is *voluntary and well considered*; b. be satisfied that the patient’s *suffering* is unbearable, *with no prospect of improvement*; c. have informed the patient about his situation and prognosis; d. have come to the conclusion, together with the patient, that there is *no reasonable alternative in the patient’s situation*; e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled; f. have exercised due medical care and attention in terminating the patient’s life or assisting in his suicide” (pp. 35–36, italics added).

The requirements set forth in the Belgian Act on Euthanasia of May 28th, 2002 are similar: “The physician who performs euthanasia commits no criminal offence when he/she ensures that: the patient has attained the age of majority or is an emancipated minor, and is *legally competent* and conscious at the moment of making the request; the request is *voluntary*, well-considered and repeated, and is not the result of any external pressure; the patient is in a *medically futile condition* of constant and unbearable physical or mental *suffering that can not be alleviated*, resulting from a serious and incurable disorder caused by illness or accident; and when he/she has

respected the conditions and procedures as provided in this Act” (Ch. II, section 3, par. 1, italics added).

3. While the Dutch act does not stipulate legal competence or decision-making capacity explicitly, the Dutch RTE Code of Practice nevertheless clarifies that for the request to be voluntary, the patient must be “decisionally competent” (p. 12; see also section 4.3, p. 26).
4. According to the Dutch RTE Code of Practice, “it must be palpable to the physician that this particular patient’s suffering is unbearable. The physician must therefore not only be able to empathise with the patient’s situation, but also see it from the patient’s point of view” (section 3.3, p. 14). For discussion of the term *palpable*, see Tuffrey-Wijne et al. (2018)
5. Note that the Belgian act, like the Dutch act, uses the language of there being “no other reasonable alternative” in the section following the one quoted above (see Ch. II, section 3, par. p. 2).
6. Note that there is high co-occurrence of ASD and anxiety (e.g., Stewart, Barnard, Pearson, Hasan, & O’Brien, 2006).
7. The DSM-5 also suggests connections between adaptive functioning and decision making (not specific to autism).
8. Wallace et al. (2016) found correlations between executive dysfunction and difficulties with adaptive function. Interestingly, Wallace et al. also found correlations between executive dysfunction in flexibility and anxiety, as well as correlations between executive dysfunction in “metacognition” and depression (metacognition includes initiation, working memory, planning/organization and task monitoring, but planning/organization seemed to be the most powerful predictor of depression). This is important because anxiety and depression are predictors of suicidality, and the finding of correlations among executive dysfunction, anxiety and depression raises the question of whether there might also be connections between executive dysfunction and suicidality.
9. Farmer, Baron-Cohen, and Skylark (2017) proposed that people with ASD make more rational decisions because they are less influenced by context/framing and decoys. But De Martino, Harrison, Knafo, Bird, and Dolan (2008) suggested that the ASD resistance to “framing effect” “reflects a failure to incorporate emotional cues into the decision process, an enhanced economic ‘rationality’ that may come at a cost of reduced behavioral flexibility”(p. 10746). De Martino et al. also noted, “Our SCR results in the context of a high-level decision task supports [sic] convergent evidence of impairment in emotional processing in autism Paradoxically, although this impairment in processing contextual emotional information protects ASD subjects from the framing bias, leading to more consistent behavior in situations of risk, it may come at a cost of the social, emotional, and behavioral deficits that characterize the condition. . . . These previous results, combined with the SCR data shown here, suggest that the failure to assign emotional salience to contextual cues and consequential lack of behavioral bias in ASD may result from an amygdala based mechanism” (pp. 10749–50).
10. See note 21.
11. When considering possible limitations on voluntariness, we should examine external constraints as well as internal constraints. External constraints that could affect the freedom or voluntariness of EAS requests might include the influence of family members or friends, social stigma (see Moses, 2018), lack of needed social supports (including therapies and material resources [Hedley et al., 2017]), expressive effects of

- law (see Schiltz, 2018), and societal endorsement of the notion that the lives of people with autism might not be worth living. In the interest of brevity, I focus here on internal constraints that might limit voluntariness. As will become clear, though, some of what I propose would apply to external constraints on voluntariness as well.
12. For additional discussion of depression and EAS, see Emanuel (2005), Levene and Parker (2011), and Rooney et al. (2018).
 13. Doernberg et al. (2016) cited a Dutch case report in which one consultant doubted a patient's competence because his/her "serious depressive disorder" "possibly impeded [the patient's] free will" and because the patient's "desire to die could be a symptom of this disorder" (p. 560). The authors also employ the distinction of the request being "a pathologically determined wish vs a rational choice" (p. 562).
 14. See Hedley et al. (2017), who reported a European depression rate of 7.6%, citing Casey et al. (2008). However, Casey et al. (2008) appeared to report a depression rate of 8.6% rather than 7.6% (p. 302).
 15. However, Mayes et al. (2013) found no correlation between IQ and suicidal ideation or attempts in children with ASD, and Storch et al. (2013) found that children with autism were more likely to have suicidal thoughts and behavior than children with Asperger syndrome. It is worth noting that studies have also found that autistic traits are positively associated with loneliness, and loneliness is associated with increased depression in adults with ASD (Mazurek, 2014; cf. Hedley et al., 2017, 2018).
 16. Cassidy and Rogers (2017) reported that adults on the spectrum are more likely to contemplate suicide than people with psychotic disorders, and nearly four times more likely to do so than the general UK population (66% vs. 17%). There seems to be some discrepancy between this latter claim and the 2014 study in which Cassidy et al. reported the same lifetime incidence of suicidal ideation for people with Asperger syndrome (66%) but claim that this rate is nine times higher than the general population. Spiers et al. (2014) suggested that the lifetime suicidal ideation rate among people in the UK might be around 7%, though, and using this figure would support Cassidy et al.'s 2014 claim. Hedley et al. (2017) reported general European rates of suicidal ideation at 9.5% (p. 3674).
 17. Recall that autistic people who can legally request EAS are less likely to have coexisting intellectual disability, and are therefore at higher risk of death by suicide.
 18. However, Storch et al. (2013) found suicidal ideation and attempts to be not significantly higher among anxious youths with ASD than among neurotypical youths without anxiety, and at lower rates than in neurotypical youths with anxiety (p. 2454). It appears to me, though, that Storch et al. might have misunderstood the figures on which these comparisons are made. Storch et al. reported that 11% of children with co-occurring ASD and clinically significant anxiety exhibited suicidal thoughts and behaviors, and cited Wunderlich, Bronisch, Wittchen and Carter (2001) in support of their claim that anxious youths with ASD have a rate of suicidal ideation and attempts similar to that of neurotypical youths without anxiety. But Wunderlich et al. reported a suicidality rate of 11.3 per 100,000 for neurotypical youths, not a rate of 11%.
 19. Moses (2018) suggested that "having a disability may be a fundamental cause of suicidal behavior," which raises the question of whether there might be a direct causal link between disabilities like ASD and suicidal behavior even when there is no mediating depression (p. 429).
 20. See, however, Verhofstadt et al.'s (2017) qualitative study of the suffering of their psychiatric patients seeking EAS.

21. Somewhat surprisingly, problems related to emotional regulation and executive function are more common than physical pain in accounts of the suffering that brings autistic people to request EAS. Case report 2017-80 states that the young woman with pervasive developmental disorder not otherwise specified had “emotion regulation problems,” and describes her suffering in the following terms: “The patient . . . was . . . [overwhelmed] by tantrums, crying and [outbursts of anger] that were caused by fear. [She could hardly be assessed because of] rapid overstimulation. . . . She was busy all day suppressing her [symptoms] in order to survive so she would not be overwhelmed and there would be an emotional outburst of anxiety or sadness.” In case 2014-77, it is reported of a man in his thirties with a longstanding diagnosis of Asperger syndrome that “He could react to things in a spontaneous and intense, sometimes extreme, manner. This often led to problems. . . . He was frustrated by his ‘forbidden’ feelings,” and had “poor frustration-tolerance” (trans. Tuffrey-Wijne et al., 2018, pp. 7–8). And in case 2013-21, the suffering of an older gentleman with self-diagnosed Asperger syndrome is described in the following terms: “He responded to everything, even the most simple circumstances, with severe panic”; and we are told that “The consultant found that the patient’s personality was very poorly emotionally integrated” (trans. Tuffrey-Wijne et al., 2018, p. 5). All three of these reports suggest problems with emotional regulation, which, as we have seen, is both common in people with ASD and can affect decision-making competence.

In addition to emotional dysregulation, we also find evidence of suffering described in terms of problems with executive function, which can affect decision making too. The young woman with pervasive developmental disorder not otherwise specified described in case 2017-80 is said to have “remained fanatically stuck to routines,” suggesting executive dysfunction in the form of cognitive inflexibility, which is very common in the executive function profiles of people on the spectrum; in fact, Wallace et al. (2016) suggested that there is a “peak deficit” or “peak difficulty” with behavioral flexibility among children on the spectrum, and that work on executive function in adults with ASD “demonstrated consistent impairments in cognitive flexibility” (p. 1072). In case 2013-21, we learn that for the older gentleman with Asperger syndrome, “It was also very difficult for the patient to have an overview of how to manage his daily life” (trans. Tuffrey-Wijne et al., 2018, p. 5). One wonders whether this aspect of his suffering might derive from executive dysfunction in the area of planning, which is also a common part of the executive function profile for people with ASD (Wallace et al. indicated that “flexibility and planning deficits are considered most characteristic of the EF [executive function] profile in ASD” [p. 1071], and found that problems with metacognition—especially planning/organization—are most associated with co-occurring depression [pp. 1071, 1080]). In case 2014-77, it is reported of the man in his thirties with a longstanding diagnosis of Asperger syndrome that “The patient’s suffering consisted of always being busy in his head with thoughts, on multiple and different levels, and not being able to exclude himself from stimuli or thought processes. He found that exhausting. He really wanted to turn off his thoughts and find rest” (trans. Tuffrey-Wijne et al., 2018, p. 7). This suggests difficulties with inhibition, an area of executive function that can also affect decision making. And in case 2016-48, we are told about an elderly woman (90–95 years old) who was only recently diagnosed with autism spectrum disorder: she exhibited “loss of executive function and mental inflexibility,” and she suffered because “She declined any help from others because she wanted to keep doing everything herself—according to rigid rituals—even when that had

become almost impossible” (trans. Tuffrey-Wijne et al., 2018, p. 11). Her suffering was clearly reflective of cognitive inflexibility, an area of executive function that can affect decision making. Strikingly, in this case report we are also told that “Because of the lack of reciprocity [sic] in communication and the seeming lack of feelings of empathy from the patient, it was difficult to judge whether and why the patient was suffering unbearably” (trans. Tuffrey-Wijne et al., 2018, p. 11). This might reflect problems with emotional regulation and communication, or it might actually represent a lack of unbearable suffering. Apparently the matter was resolved to the commission’s satisfaction, though, because we are further told that “Although to the consultant, the patient’s suffering was understandable only to a limited degree, the clearly substantiated explanations of the independent geriatric psychiatrist convinced him that *patients with an autism spectrum disorder suffer in a way that may not be directly understandable to others*” (trans. Tuffrey-Wijne et al., 2018, p. 11, italics added). What is one to say about this? If the suffering of people with ASD is not understandable to others, how can the due care criterion that the suffering be unbearable and “palpable” to the physician have been met in this case or in others involving people on the spectrum? Perhaps only autistic psychiatrists should be allowed to consult in such cases.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D.C.: American Psychiatric Association.
- Appelbaum, P. S. (2007). Assessment of patients’ competence to consent to treatment. *New England Journal of Medicine*, 357(18), 1834–1840. doi:10.1056/NEJMc074045
- Attwood, T. (1998). *Asperger’s syndrome: A guide for parents and professionals*. London: Jessica Kingsley.
- Barnhill, G., Hagiwara, T., Myles, B., Simpson, R., Brick, M., & Griswold, D. (2000). Parent, teacher, and self-report of problem and adaptive behaviors in children and adolescents with Asperger syndrome. *Diagnostique*, 25(2), 147–167. doi:10.1177/073724770002500205
- The Belgian Act on Euthanasia of May 28th, 2002 (D. Kidd & H. Nys, Trans.). (2002). *Ethical Perspectives*, 9(2–3), 182–188.
- Bishop-Fitzpatrick, L., Minshew, N., & Eack, S. (2014). A systematic review of psychosocial interventions for adults with autism spectrum disorders. In F. Volkmar, B. Reichow, & J. McPartland (Eds.), *Adolescents and adults with autism spectrum disorders* (pp. 315–327). New York, NY: Springer.
- Botha, M., & Frost, D. (2018). Extending the minority stress model to understand mental health problems experienced by the autistic population. *Society and Mental Health*, 00(0), 1–15. doi:10.1177/2156869318804297
- Casey, P., Dunn, G., Kelly, B., Lehtinen, V., Dalgard, O., Dowrick, C., & Ayuso-Mateos, J. L. (2008). The prevalence of suicidal ideation in the general population: Results from the outcome of depression international network (ODIN) study. *Social Psychiatry and Psychiatric Epidemiology*, 43(4), 299–304. doi:10.1007/s00127-008-0313-5
- Cassidy, S., Bradley, P., Robinson, J., Allison, C., McHugh, M., & Baron-Cohen, S. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger’s syndrome attending a specialist diagnostic clinic: A clinical cohort study. *The Lancet Psychiatry*, 1(2), 142–147. doi:10.1016/S2215-0366(14)70248-2

- Cassidy, S., & Rodgers, J. (2017). Understanding and prevention of suicide in autism. *The Lancet Psychiatry*, 4(6), E11. doi:10.1016/S2215-0366(17)30162-1
- Charland, L. (1998). Is Mr. Spock mentally competent? Competence to consent and emotion. *Philosophy, Psychiatry, & Psychology*, 5(1), 67–81.
- De Martino, B., Harrison, N., Knafo, S., Bird, G., & Dolan, R. (2008). Explaining enhanced logical consistency during decision making in autism. *Journal of Neuroscience*, 28(42), 10746–10750. doi:10.1523/JNEUROSCI.2895-08.2008
- Demetriou, E. A., Lampit, A., Quintana, D. S., Naismith, S. L., Song, Y. J. C., Pye, J. E., ... Guastella, A. J. (2018). Autism spectrum disorders: A meta-analysis of executive function. *Molecular Psychiatry*, 23(5), 1198–1204. doi:10.1038/mp.2017.75
- Dichter, G., Felder, J., Green, S., Rittenberg, A., Sasson, N., & Bodfish, J. (2012). Reward circuitry function in autism spectrum disorders. *Social Cognitive and Affective Neuroscience*, 7(2), 160–172. doi:10.1093/scan/nsq095
- Dierickx, S., Deliëns, L., Cohen, J., & Chambaere, K. (2017). Euthanasia for people with psychiatric disorders or dementia in Belgium: Analysis of officially reported cases. *BMC Psychiatry*, 17(1), 203. doi:10.1186/s12888-017-1369-0
- Doernberg, S., Peteet, J., & Kim, S. (2016). Capacity evaluations of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics*, 57(6), 556–565. doi:10.1016/j.psych.2016.06.005
- Dyer, O., White, C., & Garcia Rada, A. (2015). Assisted dying: Law and practice around the world. *BMJ*, 351, h4481–h4483. doi:10.1136/bmj.h4481
- The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002 (Dutch Department of Justice, Trans.). (2002). *Ethical Perspectives*, 9(2–3), 176–181.
- Eckstein, L., & Kim, S. (2017). Criteria for decision-making capacity: Between understanding and evidencing a choice. *Journal of Law and Medicine*, 24(3), 678–694.
- Emanuel, E. (2005). Depression, euthanasia, and improving end-of-life care. *Journal of Clinical Oncology*, 23(27), 6456–6458. doi:10.1200/JCO.2005.06.001
- Farmer, G., Baron-Cohen, S., & Skylark, W. (2017). People with autism spectrum conditions make more consistent decisions. *Psychological Science*, 28(8), 1067–1076.
- Geurts, H. M., De Vries, M. F., & Van den Bergh, S. (2014). Executive functioning theory and autism. In S. Goldstein & J. Naglieri (Eds.), *Handbook of executive functioning* (pp. 121–141). New York, NY: Springer.
- Ghaziuddin, M., Ghaziuddin, N., & Greden, J. (2002). Depression in persons with autism: Implications for research and clinical care. *Journal of Autism and Developmental Disorders*, 32(4), 299–306. doi:10.1023/a:1016330802348
- Ghaziuddin, M., Weidmer-Mikhail, E., & Ghaziuddin, N. (1998). Comorbidity of Asperger syndrome: A preliminary report. *Journal of Intellectual Disability Research*, 42(4), 279–283.
- Hatzenbuehler, M., Phelan, J., & Link, B. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, 103(5), 813–821.
- Hedley, D., Uljarević, M., Wilmot, M., Richdale, A., & Dissanayake, C. (2017). Brief report: Social support, depression and suicidal ideation in adults with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 47(11), 3669–3677.
- Hedley, D., Uljarević, M., Wilmot, M., Richdale, A., & Dissanayake, C. (2018). Understanding depression and thoughts of self-harm in autism: A potential mechanism involving loneliness. *Research in Autism Spectrum Disorders*, 46, 1–7.
- Hill, E. (2004). Executive dysfunction in autism. *Trends in Cognitive Sciences*, 8(1), 26–32. doi:10.1016/j.tics.2003.11.003

- Hill, T., Gray, S., Kamps, J., & Varela, R. E. (2015). Age and adaptive functioning in children and adolescents with ASD: The effects of intellectual functioning and ASD symptom severity. *Journal of Autism and Developmental Disorders*, 45(12), 4074–4083.
- Hillier, A., Fish, T., Siegel, J., & Beversdorf, D. (2011). Social and vocational skills training reduces self-reported anxiety and depression among young adults on the autism spectrum. *Journal of Developmental and Physical Disabilities*, 23(3), 267–276.
- Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *The British Journal of Psychiatry*, 208(3), 232–238.
- Hofvander, B., Delorme, R., Chaste, P., Nydén, A., Wentz, E., Ståhlberg, O., ... Leboyer, M. (2009). Psychiatric and psychosocial problems in adults with normal-intelligence autism spectrum disorders. *BMC Psychiatry*, 9(1), 35. doi:10.1186/1471-244X-9-35
- Hurtig, T., Kuusikko, S., Mattila, M.-L., Haapsamo, H., Ebeling, H., Jussila, K., ... Moilanen, I. (2009). Multi-informant reports of psychiatric symptoms among high-functioning adolescents with Asperger syndrome or autism. *Autism*, 13(6), 583–598. doi:10.1177/1362361309335719
- Kenworthy, L., Anthony, L. G., Naiman, D. Q., Cannon, L., Wills, M. C., Luong-Tran, C., ... Wallace, G. L. (2014). Randomized controlled effectiveness trial of executive function intervention for children on the autism spectrum. *Journal of Child Psychology and Psychiatry*, 55(4), 374–383. doi:10.1111/jcpp.12161
- Kim, S. (2015). The place of ability to value in the evaluation of decision-making capacity. In D. Moseley, & G. Gala (Eds.), *Philosophy and psychiatry: Problems, intersections and new perspectives* (pp. 189–203). New York, NY: Routledge.
- Kim, S., De Vries, R., & Peteet, J. (2016). Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry*, 73(4), 362–368. doi:10.1001/jamapsychiatry.2015.2887
- Kim, S., & Lemmens, T. (2016). Should assisted dying for psychiatric disorders be legalized in Canada? *Canadian Medical Association Journal*, 188(14), E337–E339.
- Kim, J., Szatmari, P., Bryson, S., Streiner, D., & Wilson, F. (2000). The prevalence of anxiety and mood problems among children with autism and Asperger syndrome. *Autism: The International Journal of Research and Practice*, 4(2), 117–132.
- Klomek, A., Marrocco, F., Kleinman, M., Schonfeld, I., & Gould, M. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(1), 40–49.
- Kluge, E. (2005). Competence, capacity, and informed consent: Beyond the cognitive-competence model. *Canadian Journal on Aging / La Revue Canadienne du Vieillessement*, 24(3), 295–304. doi:10.1353/cja.2005.0077
- Kohls, G., Schulte-Rüther, M., Nehr Korn, B., Müller, K., Fink, G. R., Kamp-Becker, I., ... Konrad, K. (2013). Reward system dysfunction in autism spectrum disorders. *Social Cognitive and Affective Neuroscience*, 8(5), 565–572. doi:10.1093/scan/nss033
- Laugeson, E., Gantman, A., Kapp, S., Orenski, K., & Ellingsen, R. (2015). A randomized controlled trial to improve social skills in young adults with autism spectrum disorder: The UCLA PEERS® Program. *Journal of Autism and Developmental Disorders*, 45(12), 3978–3989.
- Lemmens, T. (2018). Charter scrutiny of Canada's medical assistance in dying law and the shifting landscape of Belgian and Dutch euthanasia practice. *Supreme Court Law Review (2nd Series)*, 85, 459–544.

- Lemmens, T., Kim, H., & Kurz, E. (2018). Why Canada's medical assistance in dying legislation should be c(h)arter compliant and what it may help to avoid. *McGill Journal of Law and Health*, 11(1), 61–148.
- Lemmens, W. (2017). Psychiatric patients and the culture of euthanasia in Belgium. In D.A. Jones, C. Gastmans, & C. MacKellar (Eds.), *Euthanasia and assisted suicide: Lessons from Belgium* (pp. 258–277). Cambridge, UK: Cambridge University Press.
- Levene, I., & Parker, M. (2011). Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: A systematic review. *Journal of Medical Ethics*, 37(4), 205–211.
- Levin, I., Gaeth, G., Foley-Nicpon, M., Yegorova, V., Cederberg, C., & Yan, H. (2015). Extending decision making competence to special populations: A pilot study of persons on the autism spectrum. *Frontiers in Psychology*, 6, 539.
- Lim, G., Tam, W., Lu, Y., Ho, C., Zhang, M., & Ho, R. (2018). Prevalence of depression in the community from 30 countries between 1994 and 2014. *Scientific Reports*, 8(1), 2861. doi:10.1038/s41598-018-21243-x
- Luke, L., Clare, I., Ring, H., Redley, M., & Watson, P. (2012). Decision-making difficulties experienced by adults with autism spectrum conditions. *Autism: The International Journal of Research and Practice*, 16(6), 612–621.
- Mackenzie, R., & Watts, J. (2011). Including emotionality in tests of competence: How does neurodiversity affect measures of free will and agency in medical decision making? *AJOB Neuroscience*, 2(3), 27–36. doi:10.1080/21507740.2011.580491
- Mandell, D. (2018). Dying before their time: Addressing premature mortality among autistic people. *Autism: The International Journal of Research and Practice*, 22(3), 234–235. doi:10.1177/1362361318764742
- Mayes, S. D., Gorman, A., Hillwig-Garcia, J., & Syed, E. (2013). Suicide ideation and attempts in children with autism. *Research in Autism Spectrum Disorders*, 7(1), 109–119. doi:10.1016/j.rasd.2012.07.009
- Mazurek, M. (2014). Loneliness, friendship, and well-being in adults with autism spectrum disorders. *Autism: The International Journal of Research and Practice*, 18(3), 223–232. doi:10.1177/1362361312474121
- Moses, T. (2018). Suicide attempts among adolescents with self-reported disabilities. *Child Psychiatry & Human Development*, 49(3), 420–433.
- Mussey, J., Travers, B., Klinger, L. G., & Klinger, M. (2015). Decision making skills in ASD: Performance on the Iowa Gambling Task. *Autism Research: Official Journal of the International Society for Autism Research*, 8(1), 105–114. doi:10.1002/aur.1429
- Nuske, H., Hedley, D., Woollacott, A., Thomson, P., Macari, S., & Dissanayake, C. (2017). Developmental delays in emotion regulation strategies in preschoolers with autism. *Autism Research*, 10(11), 1808–1822. doi:10.1002/aur.1827
- Palmen, A., Didden, R., & Lang, R. (2012). A systematic review of behavioral intervention research on adaptive skill building in high-functioning young adults with autism spectrum disorder. *Research in Autism Spectrum Disorders*, 6(2), 602–617. doi:10.1016/j.rasd.2011.10.001
- Raja, M., Azzoni, A., & Frustaci, A. (2011). Autism spectrum disorders and suicidality. *Clinical Practice & Epidemiology in Mental Health*, 7(1), 97–105. doi:10.2174/1745017901107010097
- Raja, M. (2014). Suicide risk in adults with Asperger's syndrome. *The Lancet Psychiatry*, 1(2), 99–101. doi:10.1016/S2215-0366(14)70257-3
- Regional Euthanasia Review Committees (RTEs). (n.d.). Judgments: All statements and explanations [Oordelen: Alle Uitspraken & Uitleg]. Retrieved from <https://www.euthanasiecommissie.nl/uitspraken-en-uitleg>.

- Regional Euthanasia Review Committees (RTEs) (2017). Case file 2017-80 [Oordelen 2017-80]. Retrieved from <https://www.euthanasiacommissie.nl/binaries/euthanasiacommissie/documenten/publicaties/oordelen/2017/uitzichtloos-en-ondraaglijk-lijden/oordeel-2017-80/Oordeel%20+%202017-80.pdf>.
- Regional Euthanasia Committees (RTEs) (2015). *Code of Practice*. The Hague. Retrieved from <https://english.euthanasiacommissie.nl/documents/publications/code-of-practice/code-of-practice/code-of-practice/code-of-practice>.
- Reyna, V., & Brainerd, C. (2011). Dual processes in decision making and developmental neuroscience: A fuzzy-trace model. *Developmental Review, 31*(2), 180–206. doi:10.1016/j.dr.2011.07.004
- Richey, J. A., Damiano, C. R., Sabatino, A., Rittenberg, A., Petty, C., Bizzell, J., ... Dichter, G. S. (2015). Neural mechanisms of emotion regulation in autism spectrum disorder. *Journal of Autism and Developmental Disorders, 45*(11), 3409–3423. doi:10.1007/s10803-015-2359-z
- Rooney, W., Schuklenk, U., & van de Vathorst, S. (2018). Are concerns about irremediableness, vulnerability, or competence sufficient to justify excluding all psychiatric patients from medical aid in dying? *Health Care Analysis, 26*(4), 326–343. doi:10.1007/s10728-017-0344-8
- Samson, A., Wells, W., Phillips, J., Hardan, A., & Gross, J. (2015). Emotion regulation in autism spectrum disorder: Evidence from parent interviews and children's daily diaries. *Journal of Child Psychology and Psychiatry, 56*(8), 903–913. doi:10.1111/jcpp.12370
- Schiltz, E. (2018). The contradictory expressive functions of the americans with disabilities act and physician-assisted suicide laws. *Journal of Disability & Religion, 22*(3), 228–245. doi:10.1080/23312521.2018.1486772
- Schiltz, H. K., McVey, A. J., Dolan, B. K., Willar, K. S., Pleiss, S., Karst, J. S., ... Van Hecke, A. V. (2018). Changes in depressive symptoms among adolescents with ASD completing the PEERS® social skills intervention. *Journal of Autism and Developmental Disorders, 48*(3), 834–843. doi:10.1007/s10803-017-3396-6
- Segers, M., & Rawana, J. (2014). What do we know about suicidality in autism spectrum disorders? A systematic review. *Autism Research, 7*(4), 507–521. doi:10.1002/aur.1375
- Sizoo, B., & Kuiper, E. (2017). Cognitive behavioural therapy and mindfulness based stress reduction may be equally effective in reducing anxiety and depression in adults with autism spectrum disorders. *Research in Developmental Disabilities, 64*, 47–55. doi:10.1016/j.ridd.2017.03.004
- Spain, D., Sin, J., Chalder, T., Murphy, D., & Happé, F. (2015). Cognitive behaviour therapy for adults with autism spectrum disorders and psychiatric co-morbidity: A review. *Research in Autism Spectrum Disorders, 9*, 151–162. doi:10.1016/j.rasd.2014.10.019
- Spek, A., van Ham, N., & Nyklíček, I. (2013). Mindfulness-based therapy in adults with an autism spectrum disorder: A randomized controlled trial. *Research in Developmental Disabilities, 34*(1), 246–253. doi:10.1016/j.ridd.2012.08.009
- Spiers, N., Bebbington, P., Dennis, M., Brugha, T., McManus, S., Jenkins, R., & Meltzer, H. (2014). Trends in suicidal ideation in England: The national psychiatric morbidity surveys of 2000 and 2007. *Psychological Medicine, 44*(1), 175–183. doi:10.1017/S0033291713000317
- Spikins, P., Wright, B., & Scott, C. (2018). Autism spectrum conditions affect preferences in valued personal possessions. *Evolutionary Behavioral Sciences, 12*(2), 99–112.
- Sterling, L., Dawson, G., Estes, A., & Greenson, J. (2008). Characteristics associated with presence of depressive symptoms in adults with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 38*(6), 1011–1018. doi:10.1007/s10803-007-0477-y

- Stewart, M., Barnard, L., Pearson, J., Hasan, R., & O'Brien, G. (2006). Presentation of depression in autism and Asperger syndrome: A review. *Autism: The International Journal of Research and Practice*, *10*(1), 103–116. doi:[10.1177/1362361306062013](https://doi.org/10.1177/1362361306062013)
- Storch, E. A., Sulkowski, M. L., Nadeau, J., Lewin, A. B., Arnold, E. B., Mutch, P. J., ... Murphy, T. K. (2013). The phenomenology and clinical correlates of suicidal thoughts and behaviors in youth with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *43*(10), 2450–2459. doi:[10.1007/s10803-013-1795-x](https://doi.org/10.1007/s10803-013-1795-x)
- Thienpont, L., Verhofstadt, M., Van Loon, T., Distelmans, W., Audenaert, K., & De Deyn, P. (2015). Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: A retrospective, descriptive study. *BMJ Open*, *5*(7), E007454. doi:[10.1136/bmjopen-2014-007454](https://doi.org/10.1136/bmjopen-2014-007454)
- Thomson, K., Riosa, P. B., & Weiss, J. (2015). Brief report of preliminary outcomes of an emotion regulation intervention for children with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, *45*(11), 3487–3495. doi:[10.1007/s10803-015-2446-1](https://doi.org/10.1007/s10803-015-2446-1)
- Tomanik, S., Pearson, D., Loveland, K., Lane, D., & Shaw, J. B. (2007). Improving the reliability of autism diagnoses: Examining the utility of adaptive behavior. *Journal of Autism and Developmental Disorders*, *37*(5), 921–928. doi:[10.1007/s10803-006-0227-6](https://doi.org/10.1007/s10803-006-0227-6)
- Tuffrey-Wijne, I., Curfs, L., Finlay, I., & Hollins, S. (2018). Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: An examination of nine relevant euthanasia cases in the Netherlands (2012–2016). *BMC Medical Ethics*, *19*(1), 17. doi:[10.1186/s12910-018-0257-6](https://doi.org/10.1186/s12910-018-0257-6)
- Van Orden, K., Merrill, K., & Joiner, T. (2005). Interpersonal-psychological precursors to suicidal behavior: A theory of attempted and completed suicide. *Current Psychiatry Reviews*, *1*(2), 187–196. doi:[10.2174/1573400054065541](https://doi.org/10.2174/1573400054065541)
- Verhofstadt, M., Thienpont, L., & Peters, G. (2017). When unbearable suffering incites psychiatric patients to request euthanasia: Qualitative study. *British Journal of Psychiatry*, *211*(4), 238–245. doi:[10.1192/bjp.bp.117.199331](https://doi.org/10.1192/bjp.bp.117.199331)
- Wallace, G., Kenworthy, L., Pugliese, C., Popal, H., White, E., Brodsky, E., & Martin, A. (2016). Real-world executive functions in adults with autism spectrum disorder: Profiles of impairment and associations with adaptive functioning and co-morbid anxiety and depression. *Journal of Autism and Developmental Disorders*, *46*(3), 1071–1083. doi:[10.1007/s10803-015-2655-7](https://doi.org/10.1007/s10803-015-2655-7)
- Walsh, E., Holloway, J., & Lydon, H. (2018). An evaluation of a social skills intervention for adults with autism spectrum disorder and intellectual disabilities preparing for employment in Ireland: A pilot study. *Journal of Autism and Developmental Disorders*, *48*(5), 1727–1741. doi:[10.1007/s10803-017-3441-5](https://doi.org/10.1007/s10803-017-3441-5)
- Walton, K. M., & Ingersoll, B. R. (2013). Improving social skills in adolescents and adults with autism and severe to profound intellectual disability: A review of the literature. *Journal of Autism and Developmental Disorders*, *43*(3), 594–615. doi:[10.1007/s10803-012-1601-1](https://doi.org/10.1007/s10803-012-1601-1)
- Wang, Q., DiNicola, L., Heymann, P., Hampson, M., & Chawarska, K. (2018). Impaired value learning for faces in preschoolers with autism spectrum disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(1), 33–40. doi:[10.1016/j.jaac.2017.10.014](https://doi.org/10.1016/j.jaac.2017.10.014)
- Wing, L. (1981). Asperger's syndrome: A clinical account. *Psychological Medicine*, *11*(1), 115–129. doi:[10.1017/S0033291700053332](https://doi.org/10.1017/S0033291700053332)
- Wong, C., Odom, S. L., Hume, K. A., Cox, A. W., Fettig, A., Kucharczyk, S., ... Schultz, T. R. (2015). Evidence-based practices for children, youth, and young adults with autism

- spectrum disorder: A comprehensive review. *Journal of Autism and Developmental Disorders*, 45(7), 1951–1966. doi:[10.1007/s10803-014-2351-z](https://doi.org/10.1007/s10803-014-2351-z)
- Wunderlich, U., Bronisch, T., Wittchen, H.-U., & Carter, R. (2001). Gender differences in adolescents and young adults with suicidal behaviour. *Acta Psychiatrica Scandinavica*, 104(5), 332–339. doi:[10.1111/j.1600-0447.20010.00432.x](https://doi.org/10.1111/j.1600-0447.20010.00432.x)
- Zablotsky, B., Bradshaw, C., Anderson, C., & Law, P. (2013). The association between bullying and the psychological functioning of children with autism spectrum disorders. *Journal of Developmental & Behavioral Pediatrics*, 34(1), 1–8. doi:[10.1097/DBP.0b013e31827a7c3a](https://doi.org/10.1097/DBP.0b013e31827a7c3a)
- Zhang, L., Tang, J., Dong, Y., Ji, Y., Tao, R., Liang, Z., ... Wang, K. (2015). Similarities and differences in decision-making impairments between autism spectrum disorder and schizophrenia. *Frontiers in Behavioral Neuroscience*, 9 (September), 259. doi:[10.3389/fnbeh.2015.00259](https://doi.org/10.3389/fnbeh.2015.00259)