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Suicidal ideation and behavior among autistic, self-reported autistic, and non-autistic adults in Latin America

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ABSTRACT

Objective: Suicidal ideation and behavior are recognized as major public-health concerns among autistic adults, yet almost all existing evidence comes from high-income, English-speaking countries. This study is the first multi-country investigation of lifetime suicidal ideation and behavior in confirmed autistic, adults who suspect they are autistic, and non-autistic adults across seven Latin American countries.

Methods: Using the culturally adapted Suicide Behaviors Questionnaire–Autism Spectrum Conditions (SBQ-ASC), a cross-sectional online survey was conducted through the Red Espectro Autista Latinoamérica(REAL) network. The final analytic sample comprised 1,083 adults classified as confirmed autistic ($n = 387$), adults who suspect they are autistic ($n = 188$), or non-autistic ($n = 508$).

Results: Lifetime suicidality differed markedly across groups (all χ^2 $p < 0.001$): lifetime suicide attempt was reported by 22.5%, 14.0%, and 5.7% respectively. Confirmed autistic adults had 3.96- to 5.32-fold higher odds and adults who suspect they are autistic adults 3.44- to 4.93-fold higher odds of every lifetime outcome compared to non-autistic adults (all $p < 0.001$) in models adjusted for country of residence only. Past-12-month intense suicidal ideation was reported by 70.0%, 65.4%, and 33.1% respectively; adjusted odds ratios ranged from 2.72 to 5.08 (all $p \leq 0.01$).

Conclusions: In this non-probability online sample recruited across several Latin American countries, both diagnosed autistic adults and adults who suspect they are autistic reported elevated, graded levels of suicidal ideation and behavior relative to non-autistic adults after adjusting for country of residence. These preliminary findings highlight the potential value of autism-informed suicide prevention and of expanding diagnostic and mental-health services in the region, and underscore the need for confirmatory research using representative samples and multivariable adjustment.

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Introduction

Suicide has immense societal, psychological, and economic repercussions (Jain et al. 2024; Peterson, Haileyesus, and Stone 2024). Across the Western Hemisphere it remains one of the leading causes of death among young people. In Latin America and the Caribbean, the age-standardized suicide mortality rate rose from 8.6 to 10.9 per 100,000 between 2001 and 2021, a 26.7% increase, making this the only World Health Organization region to record a sustained rise since 2000 (Pan American Health Organization 2025). The trend is steeper in the countries represented here, where the average rate increased from 13.2 to 15.4 per 100,000 over the same period, underscoring the urgency of prevention efforts in the region.

Within this escalating public health crisis at the macro and micro levels, certain subgroups of individuals are at an even heightened risk for suicide, as is the case for autistic adults. For example, systematic reviews and meta-analyses have consistently

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documented that autistic individuals face substantially elevated lifetime rates of suicidal ideation (SI) and behavior compared with the general population. A recent meta-analysis that included 52 studies with a sample of almost 90 thousand autistic participants highlighted that approximately 37% of autistic adults report lifetime suicidal ideation and 15% report a lifetime suicide attempt, with a past-year prevalence of ideation reaching approximately 25% (Huntjens et al. 2024). Moreover, relative to non-autistic adults, autistic individuals show more than three times the odds of suicidal ideation or attempts (OR = 3.32; Blanchard et al. 2021), and the risk of completed suicide is nearly three times higher even after accounting for psychiatric comorbidity (RR = 2.85; Hirvikoski et al. 2016; Santomauro et al. 2024). This mortality data underscore the gravity of this disparity: premature death among autistic adults occurs on average two decades earlier than among non-autistic peers, resulting in suicide being the leading cause of death among this subgroup, but this trend is particularly pronounced among autistic women, non-binary individuals, and those with co-occurring conditions such as attention-deficit/hyperactivity disorder (ADHD), depression, and post-traumatic stress disorder (Cassidy et al. 2018b; Newell et al. 2023). Taken together, these findings establish suicidality as one of the most serious and well-documented health disparities facing autistic adults globally and provide the evidentiary foundation against which the present study's findings must be interpreted.

Autism and suicide risk factors

A growing body of research has identified autism-specific psychological and social mechanisms that help explain this heightened vulnerability. Chief among them is camouflaging or masking, the effortful suppression of autistic traits to meet neurotypical expectations which autistic adults describe as profoundly exhausting and which is linked to autistic burnout, erosion of identity, delayed diagnosis, and suicidal ideation (Cassidy et al. 2018b; Newell et al. 2023; Raymaker et al. 2020). Additional contributors include chronic sensory overload, difficulties with emotion regulation and executive functioning, and elevated social isolation and peer victimization, which together heighten vulnerability to hopelessness, thwarted belonging, and self-harm. Autistic individuals also show hyperresponsiveness of the hypothalamic-pituitary-adrenal (HPA) axis to social and novel demands (Dunlavey 2018; Fuld 2018), so that everyday situations may be experienced as chronically stressful or even traumatic.

These individual-level mechanisms are embedded within broader social and structural contexts. Drawing on the minority stress framework, originally developed to explain health disparities among marginalized groups and increasingly applied to autistic populations, elevated suicidality is conceptualized not as an inherent consequence of autistic neurology but as the cumulative result of stigma, discrimination, and the chronic burden of navigating environments that fail to accommodate autistic people (Botha and Frost 2020). Such stressors are associated with poorer mental health and with suicidal ideation and attempts that often begin early in life (Moseley et al. 2025). Consistent with this perspective, the double empathy problem reframes autistic–non-autistic communication difficulties as bidirectional rather than as deficits residing in autistic individuals, highlighting how structural misunderstanding and chronic social rejection contribute to the thwarted belonging and perceived burdensomeness that are established precursors of suicidal ideation (Milton 2012; Mitchell, Sheppard, and Cassidy 2021). Importantly, the mechanisms reviewed above (camouflaging, autistic burnout, minority stress, altered stress physiology, and the double empathy problem) provide a conceptual context for interpreting group differences but were not directly measured in the present study. However, we therefore treat them as plausible explanatory frameworks rather than as pathways tested by our data.

Autism and suicidal behavior in Latin America

In low- and middle-income country (LMIC) contexts, these vulnerabilities inherent to minorities intersect with additional structural adversities that intensify risk and further constrain help-seeking possibilities (McConkey 2022). Across Latin America, autistic adults face not only the before mentioned stressors, but also chronic socioeconomic and political instability and hardship, including food insecurity, unemployment, and limited income, in addition to severely fragmented and underfunded provision of mental health services, extended diagnostic waiting times, high diagnostic and treatment costs, and sociocultural factors such as machismo culture, familism, and stigma around mental health disclosure that may further elevate risk (Cabrera-Mendoza, Fries, and Polimanti 2025; Montiel-Nava et al. 2020, 2024). Moreover, the near-absence of neurodiversity-affirming care (e.g. the notion that state and society should

accommodate neuro-cognitive differences rather than viewing them through a medical framework that sees autism as a deficit needing a cure) leaves LMICs poorly equipped to meet diverse needs (Gulati et al. 2023; McLennan et al. 2025). As a result, autistic adults who do have access to care frequently encounter providers unprepared to recognize or respond to their needs (Cherewick et al. 2023). These compounding adversities suggest that minority stress and structural exclusion may operate with particular force in the Latin American context, amplifying already-elevated suicidal risk and making regionally grounded, culturally informed research not merely valuable but essential.

Despite robust evidence from English-speaking countries to our knowledge, no peer-reviewed study has reported empirical estimates of suicidal ideation or behavior in autistic adults drawn from a Latin American sample. To gauge the extent of this gap, we conducted a scoping search in PubMed/MEDLINE, APA PsycINFO, Web of Science, LILACS, and SciELO on 21 June 2026, combining autism, suicidality, and Latin American country/regional terms (full Boolean strings and eligibility criteria are provided in the Supplementary Table S1). The search returned 127 records; after de-duplication and title/abstract and full-text screening, none reported suicidality outcomes in a Latin American sample of autistic adults. The only records at the autism–suicidality intersection were two narrative reviews (Musich, Berardo, and Aragón-Daud 2024; Ruggieri 2020), an instrument-adaptation study by the present authors (the Spanish-language SBQ-ASC; Montiel-Nava et al. 2026), and a Brazilian analysis documenting the statistical invisibility of autistic people in national suicide-mortality data (Dalvi-Garcia et al. 2026). The present study, therefore, provides, to our knowledge, the first empirical estimates of suicidality in autistic adults in the region.

The present multi-country study was conducted through the Red Espectro Autista Latinoamérica(REAL) network, a collaborative alliance of researchers, clinicians, autistic adults, and advocates from Argentina, Brazil, Chile, the Dominican Republic, Mexico, Uruguay, and Venezuela. REAL was established to generate culturally relevant evidence and to advocate for improved autism diagnosis and services across the region (Paula et al. 2025). As part of this initiative, the Suicide Behaviors Questionnaire-Autism Spectrum Conditions (SBQ-ASC)was rigorously adapted for use in Latin America following the ITC Guideline, in Spanish (Montiel-Nava et al. 2026) and Portuguese (Franco et al. 2026). A multi-country network design was essential to examine whether suicidality risk in autistic adults is consistent across diverse national contexts that differ in mental health infrastructure and risk factors (e.g. autism awareness, stigma, service availability).

Using this culturally adapted measure, the current study examined suicidal ideation and behavior among confirmed autistic, suspected autistic, and non-autistic adults across seven participating countries. The specific aims were to: (1) describe and compare lifetime prevalence of suicidal ideation and behavior at four levels of increasing severity across the three autism-status groups; (2) examine past 12-month prevalence of intense suicidal ideation at three frequency levels across groups, providing a current, rather than exclusively historical picture of suicidal risk in this population; and (3) evaluate whether autism status remained independently associated with both lifetime and past 12-month suicidality outcomes after adjusting for country of residence. Grounded in the minority stress framework, and consistent with findings from high-income countries (HIC) where elevated suicidal risk in autistic adults has been linked to stigma, camouflaging, and systemic exclusion rather than autistic neurology per se, we hypothesized that confirmed and suspected autistic adults, who face compounded barriers to diagnosis, services, and social inclusion across Latin America would report significantly elevated rates across all lifetime severity levels and higher frequencies of past 12-month intense suicidal ideation compared with non-autistic adults. By including both formally diagnosed and self-identified autistic adults, employing a regionally validated autism-informed instrument, and capturing both lifetime and current suicidality, this study provides the first cross-national evidence base for autism-informed suicide prevention in Latin America and contributes to the growing literature on suicidality in underserved autistic populations globally.

Methods

Study design

This was a cross-sectional, multi-country online survey study examining suicidal ideation and behavior among autistic and non-autistic adults in Latin America. The study was conducted through the Red Espectro Autista Latinoamérica (REAL) network and approved by the Institutional Review Board [University of Texas Rio Grande Valley Institutional Review Board]

Participants

Participants were adults aged 18 years and older who self-identified as autistic (with or without a formal diagnosis) or non-autistic and resided in one of seven participating countries: Argentina, Brazil, Chile, Dominican Republic, Uruguay, Venezuela, and Mexico.

Brazil contributed substantially more respondents ($n = 6{,}261$) than any other country (over twenty times the size of most national samples), which would have caused the pooled estimates and the country-adjusted models to be dominated by a single national context. To preserve the multi-country structure of the study, the Brazilian data were reduced to a size comparable with the other countries. Because confirmed autistic respondents were relatively rare in the Brazilian pool (12.3%), a simple random draw would have left this key group thinly represented ($\approx$ 25 cases); we therefore selected 203 Brazilian respondents using disproportionate stratified random selection by autism status, oversampling confirmed autistic respondents to ensure adequate representation of all three groups in the comparative analyses. By design, the resulting subsample's autism-status distribution does not mirror the full Brazilian pool. Importantly, because selection was based on autism status (the exposure) rather than on suicidality (the outcome), this procedure does not bias the exposure–outcome associations reported here. All cases from Argentina ($n = 267$), Chile ($n = 185$), Dominican Republic ($n = 2$), Mexico ($n = 29$), Uruguay ($n = 195$), and Venezuela ($n = 202$) were retained in full. Participants were classified into three groups based on self-reported autism diagnosis: confirmed autistic ('Yes'), suspected autistic ('Suspect to be autistic'), and non-autistic ('No').

Procedure

Study information was disseminated through REAL network partners *via* flyers, social media posts, and emails. Data were collected between June 2025 and January 2026. Interested individuals accessed the survey directly through a secure link to the UTRGV REDCapplatform. The survey was fully anonymous; no personally identifiable information (name, email, phone number, or IP address) was collected. To prevent duplicate submissions, the REDCap survey was configured to permit only one response per device. No attention-check items were embedded in the survey, and completion of the AQ-10 served as the minimum completion criterion for inclusion in analysis. Participants were informed that proceeding with the survey constituted their consent to participate. Participants were advised that the survey included questions about suicidal thoughts and behaviors that some people may find distressing, that participation was voluntary, and that they could skip any item or withdraw at any point by closing the survey without penalty. A list of country-specific crises and mental-health resources was presented on the consent page. Because the survey was fully anonymous and collected no identifying information (including no IP address), direct individual follow-up of acute risk was not possible; this constraint was disclosed during consent, and the design therefore prioritized universal, immediate access to crisis resources for all participants regardless of their responses. The protocol, including these procedures, was approved by the [BLINDED] Institutional Review Board.

The survey consisted of four sections: sociodemographic questions, the Spanish and Portuguese-adapted SBQ-ASC, questions on experiences of abuse and loneliness, and an autism symptoms screener. Data were stored securely on the HIPAA-compliant REDCap server and downloaded only by the research team for analysis.

Measures

Demographic and clinical characteristics

Demographic and clinical information were collected using a self-report questionnaire specifically developed for this study by the *Red Espectro Autista Latinoamérica (REAL)* network. The instrument incorporated selected items from previous REAL studies conducted across Latin America, thereby ensuring cultural relevance, linguistic appropriateness, and comparability with prior regional research on autistic populations.

The questionnaire assessed key sociodemographic and health-related variables, including age (18 years and older), gender identity (with options for woman, man, non-binary, other, and prefer not to say), highest level of education attained, current employment status, student status in higher education, lifetime history of psychiatric diagnoses (anxiety, depression, bipolar disorder, obsessive-compulsive disorder, eating disorders, personality disorders, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, schizophrenia, sensory processing disorder, sleep problems, and others), autism status (confirmed diagnosis, suspected autistic, or non-autistic), details of autism diagnosis (age at diagnosis and who provided the diagnosis), access to mental health support in the

past 12 months, presence of chronic medical conditions, living arrangements, household composition, perceived adequacy of income to maintain standard of living, and experiences of financial hardship (including food insecurity in the previous year). All questions included a 'prefer not to answer' option where appropriate, and responses were collected anonymously to encourage honest reporting. This questionnaire was administered in Spanish and Portuguese for the Brazilian sample.

Autism symptom screening

Autistic traits were assessed using the Autism Spectrum Quotient–10 (AQ-10; Allison, Auyeung, and Baron-Cohen 2012), a brief 10-item self-report screening instrument designed to identify adults who may warrant further assessment for autism spectrum conditions. Each item is rated on a 4-point Likert scale (definitely agree, slightly agree, slightly disagree, definitely disagree) and scored dichotomously (0 or 1), yielding a total score ranging from 0 to 10. A score of 6 or above is recommended as the clinical referral threshold, above which further diagnostic assessment is indicated. The AQ-10 has demonstrated good sensitivity (0.88) and specificity (0.91) for identifying autistic adults in community samples (Allison, Auyeung, and Baron-Cohen 2012), and has been validated for use in Spanish-speaking populations. In the present study, AQ-10 total scores were used as an independent validity check on the three-group autism status classification.

Reliability in the present sample

For the AQ-10, internal consistency (KR-20, appropriate for dichotomously scored items) was 0.73 overall, 0.73 for the Spanish version, and 0.71 for the Portuguese version. Because the SBQ-ASC lifetime and past-12-month indicators used here are derived from single ordinal items rather than a summed scale, internal-consistency coefficients are not applicable; we therefore evaluated the derived indicators through their monotonic ordering across autism-status groups and their convergence with AQ-10 status, and we rely on the published linguistic and cultural validation of the Spanish SBQ-ASC (Montiel-Nava et al. 2026) and the Brazilian-Portuguese (Franco et al. 2026) adaptations.

To assess the validity of the autism status classification, AQ-10 total scores were compared across the three groups. The overall model was highly significant ($F(2, 1004) = 464.79$, $p < 0.001$, $\eta^2 = 0.48$), indicating that autism group membership accounted for 48% of the variance in AQ-10 scores—a very large effect. Mean scores followed the expected gradient: confirmed autistic adults scored highest ($M = 6.80$, $SD = 2.04$), above the AQ-10 clinical referral cutoff of 6; suspected autistic adults scored intermediate ($M = 4.94$, $SD = 2.12$); and non-autistic adults scored lowest ($M = 2.77$, $SD = 1.67$). Post-hoc comparisons confirmed that all three groups differed significantly from one another (all $p < 0.001$), with each group occupying a statistically distinct position on the autistic trait continuum. Complementary analyses using the AQ-10 clinical cutoff score of 6 further confirmed this pattern ($\chi^2(2) = 426.57$, $p < 0.001$), with 75.5% of confirmed autistic, 38.3% of suspected autistic, and only 5.7% of non-autistic adults scoring at or above the cutoff. This proportion is open to several non-exclusive interpretations: attenuated self-reported traits associated with camouflaging or masking; heterogeneity and possible misclassification within a self-identified group; measurement non-invariance of the AQ-10 across languages and cultural contexts; and the contribution of co-occurring conditions to autism self-identification. We therefore treat this group as self-identifying rather than as undiagnosed autistic adults, and we report a sensitivity analysis restricted to those scoring AQ-10 ≥ 6 (Supplementary Table S2).

Suicide behavior

Suicidality was assessed using the Suicide Behaviors Questionnaire – Autism Spectrum Conditions (SBQ-ASC), a self-report measure specifically developed for autistic adults without intellectual disability. The SBQ-ASC was designed to overcome limitations of generic suicidality tools by using autism-friendly language, clear response formats, and items that better capture the phenomenology of suicidal thoughts and behaviors in autistic individuals. The original English version consists of six items assessing lifetime suicidal ideation and behavior, frequency and duration of suicidal thoughts, perceived likelihood of future suicidal acts, communication of suicidal thoughts to others, and reasons for not disclosing such thoughts. The instrument includes specific classification schemes to assess suicidal ideation and behavior. Lifetime prevalence is measured using four binary severity indicators derived from a single five-category item, while past 12-month intense suicidal ideation is evaluated using three binary frequency indicators.

For the current study, we used the Spanish and Portuguese versions of the SBQ-ASC (Franco et al.

2026; Montiel-Nava et al. 2026), which underwent a rigorous linguistic and cultural adaptation process for use in Latin America and Spain. This adaptation followed the International Test Commission (ITC) Guidelines for Translating and Adapting Tests and the Ecological Validity Framework, incorporating forward and back-translation, expert panel review, and community consultation with autistic adults across seven Spanish-speaking countries and Brazilian individuals.

Statistical analysis

All analyses were conducted in IBM SPSS Statistics version 29. To avoid quasi-complete separation resulting from the very small number of participants from the Dominican Republic ($n = 2$), this subgroup was retained in descriptive analyses but excluded from the primary inferential models. As a sensitivity analysis, all primary models were re-estimated with and without participants from the Dominican Republic to evaluate the robustness of the findings. Descriptive statistics (means, standard deviations, frequencies, and percentages) were calculated for all variables. The three autism-status groups (confirmed autistic, suspected autistic, non-autistic) were compared on continuous variables (e.g. age, AQ-10 total score) using one-way analysis of variance with post-hoc comparisons and η^2 effect sizes, and on categorical variables using Pearson χ^2 tests, with Fisher's exact tests used when expected cell counts were small. We evaluated assumptions as follows: Pearson χ^2 tests were used for categorical variables, with Fisher's exact tests applied when >20% of cells had expected counts < 5 (particularly for small countries). For the AQ-10 one-way ANOVA, Levene's test indicated violated homogeneity of variances; we therefore report Welch's F statistic as a robust alternative.

All analyses were conducted in IBM SPSS Statistics version 29. Descriptive statistics (means, standard deviations, frequencies, and percentages) were calculated for all variables. The three autism-status groups (confirmed autistic, suspected autistic, non-autistic) were compared on continuous variables (e.g. age, AQ-10 total score) using one-way analysis of variance with post-hoc comparisons and η^2 effect sizes, and on categorical variables using Pearson χ^2 tests, with Fisher's exact tests used when expected cell counts were small. The distribution of autism status across countries was examined with a χ^2 test. Construction of the analytic sample, including the down-sampling of the Brazilian subsample, is described in the Participants section.

Lifetime suicidal ideation and behavior were operationalized as four cumulative binary indicators of increasing severity (any ideation, serious ideation or worse, planning or attempt, and lifetime attempt) derived from a single five-category item, and past-12-month intense ideation as three cumulative frequency indicators (any, monthly or more, weekly or more) derived from a single frequency item. Group prevalences are reported with Wilson score 95% confidence intervals. Because these indicators are nested thresholds on a common underlying item rather than independent outcomes, we report threshold-specific binary models for clinical interpretability and complement them with models that exploit the full ordinal structure.

The primary inferential models were binary logistic regressions predicting each outcome from autism status, adjusted for country of residence (Uruguay as the reference country), with non-autistic adults as the reference group. Adjusted odds ratios are reported with 95% confidence intervals, and model fit is summarized using the Nagelkerke R^2. To assess whether these associations were independent of group differences in sociodemographic and clinical characteristics, we fit three nested logistic regression models for each outcome: Model 1 adjusted for country only; Model 2 added age, gender, education, employment, income sufficiency, and food insecurity; and Model 3 further added eight co-occurring psychiatric conditions. To make use of the full ordinal structure of the outcomes, we additionally fit a proportional-odds model where the assumption of parallel lines was supported (evaluated with a test of parallel lines) and a continuation-ratio model where it was not.

Finally, to evaluate the robustness of the findings for the suspected autistic group, we conducted a sensitivity analysis by restricting that group to participants scoring at or above the AQ-10 clinical referral threshold (≥ 6), leaving the confirmed-autistic and non-autistic groups unchanged. Missing data were handled by listwise deletion within each model, yielding complete-case samples of $N = 979$ (lifetime) and $N = 936$ (past-12-month). Statistical significance was set at $p < 0.05$ (two-tailed).

Results

Participant flow and missing data

A total of 65 cases were excluded from analyses because they did not provide a response to the item

assessing autism diagnosis or self-identification, with country-specific exclusions of 32 participants from Argentina, 15 from Chile, and 18 from Venezuela. This yielded a working dataset of 1,083 adults. Because the two participants from the Dominican Republic were too few to support a country-level adjustment, the Dominican Republic was retained in descriptive analyses but excluded from the country-adjusted logistic regression models. For these models, sample sizes further varied by outcome due to listwise exclusion of participants who did not respond to specific suicidality items. The lifetime suicidality models (any SI, serious SI, planning/attempt, and lifetime attempt) each included $n = 977$, while the three past 12-month suicidal ideation models each included $n = 934$ (90.2% and 86.2% of the 1,083-case working dataset, respectively). To assess whether missingness was systematic, completers and non-completers were compared on autism status; the pattern of missing data was similar across groups and is not expected to have introduced substantial bias into the autism-status estimates.

Autism status by country

The distribution of autism status varied significantly across the seven participating Latin American countries (Pearson $\chi^2(10) = 45.85$, $p < 0.001$; see Table 1). Among the six countries with sufficient cell sizes, the proportion of confirmed autistic participants was highest in Chile (45.9%) and Venezuela (37.6%), followed by Brazil (36.0%), while non-autistic adults formed the majority in Uruguay (56.9%) and Venezuela (51.0%). The suspected autistic group was largest in Brazil (26.6%) and Argentina (23.2%).

Demographic and clinical characteristics

As shown in Table 1, statistically significant differences across the three autism-status groups were observed on all sociodemographic and clinical variables examined (all Pearson χ^2 or ANOVA tests $p < 0.001$, unless otherwise noted). Confirmed autistic adults were the youngest group ($M = 34.76$ years, SD = 10.63), followed by suspected autistic adults ($M = 39.97$, SD = 10.39), while non-autistic adults were the oldest ($M = 42.68$, SD = 12.89; F(2, 1073) = 50.21, $p < 0.001$). Women comprised the majority across all three groups, though they were most over-represented among non-autistic participants (78.3%). Non-binary identification was substantially more prevalent among confirmed autistic adults (5.7%) than in the suspected autistic (1.6%) or non-autistic (0.4%) groups ($\chi^2(8) = 38.18$, $p < 0.001$). University-level education was common across groups, with non-autistic adults reporting the highest attainment rate (70.4% vs. 59.6% and 58.8% for suspected and confirmed autistic adults, respectively; $\chi^2(8) = 29.93$, $p < 0.001$). Confirmed autistic adults were least likely to report current paid employment (56.8%), compared with 72.3% of suspected autistic and 77.1% of non-autistic adults ($\chi^2(4) = 46.41$, $p < 0.001$), although they showed the highest rate of current enrollment in higher education (32.1%; $\chi^2(4) = 17.37$, $p = 0.002$).

Psychiatric comorbidity was substantially elevated in both autistic groups. Lifetime diagnoses of anxiety (70.3% confirmed, 55.9% suspected, 36.8% non-autistic), depression (63.0%, 51.1%, 31.1%), ADHD (27.9%, 8.5%, 4.7%), sleep problems (35.4%, 29.8%, 15.6%), post traumatic stress disorder (PTSD) (17.1%, 10.6%, 4.1%), eating disorders (12.7%, 8.5%, 4.3%), obsessive-compulsive disorder (OCD) (15.2%, 8.0%, 1.6%), and sensory processing disorder (15.8%, 4.8%, 1.0%) all differed significantly across groups (all $p < 0.001$). Only 8.8% of confirmed autistic adults and 25.5% of suspected autistic adults reported no lifetime psychiatric diagnosis, compared with 43.1% of non-autistic adults ($\chi^2(2) = 129.54$, $p < 0.001$). Socioeconomic disparities were also marked: confirmed autistic adults were least likely to report sufficient income (47.5% vs. 53.7% suspected and 72.4% non-autistic; $\chi^2(4) = 65.11$, $p < 0.001$), and both autistic groups experienced greater food insecurity in the past year ($\chi^2(10) = 84.67$, $p < 0.001$).

Lifetime rates of suicidal ideation and behavior

Lifetime rates of suicidal ideation and behavior were examined using four binary severity indicators derived from a single five-category item among participants with complete data on that item ($N = 979$; the two Dominican Republic participants are retained here as descriptive cases, whereas the country-adjusted regression models reported below exclude them, $n = 977$). Rates differed markedly across groups at every severity level (all Pearson χ^2 $p < 0.001$; see Table 2). Any suicidal ideation or behavior was endorsed by 85.1% of confirmed autistic adults, 83.7% of suspected autistic adults, and 55.5% of non-autistic adults. Serious suicidal ideation or worse was reported by 65.9%, 65.1%, and 29.2%, respectively. Suicidal planning or attempt was endorsed by 45.0%, 40.1%, and 17.6%, and lifetime suicide attempt by 22.5%, 14.0%, and 5.7%. A clear severity gradient was evident: although

Table 1. Sociodemographic and clinical characteristics of the sample by autism group.

Characteristic	Confirmed Autistic ($n = 387$)	Suspected Autistic ($n = 188$)	Non-autistic ($n = 508$)	Total ($N = 1,083$)
Age (years), Mean (SD)	34.76 (10.63)	39.97 (10.39)	42.68 (12.89)	39.37 (12.23)
Gender, *n* (%)				
Woman	255 (65.9%)	142 (75.5%)	398 (78.3%)	795 (73.4%)
Man	108 (27.9%)	43 (22.9%)	107 (21.1%)	258 (23.8%)
Non-binary	22 (5.7%)	3 (1.6%)	2 (0.4%)	27 (2.5%)
Other / Prefer not to say	2 (0.5%)	0 (0.0%)	0 (0.0%)	2 (0.2%)
Highest level of education, *n* (%)				
University	227 (58.7%)	112 (59.6%)	357 (70.4%)	696 (64.4%)
Technical / Professional training	30 (7.8%)	20 (10.6%)	45 (8.9%)	95 (8.8%)
Tertiary / Post-secondary	56 (14.5%)	32 (17.0%)	65 (12.8%)	153 (14.1%)
Secondary	70 (18.1%)	23 (12.2%)	37 (7.3%)	130 (12.0%)
Primary / Basic	3 (0.8%)	1 (0.5%)	3 (0.6%)	7 (0.6%)
Currently has paid employment, *n* (%)	220 (56.8%)	136 (72.3%)	390 (77.1%)	746 (69.0%)
Currently enrolled in higher education, *n* (%)	124 (32.1%)	54 (28.7%)	134 (26.5%)	312 (28.8%)
Lifetime psychiatric diagnosis, *n* (%)				
Anxiety	272 (70.3%)	105 (55.9%)	187 (36.8%)	564 (52.1%)
Depression	244 (63.0%)	96 (51.1%)	158 (31.1%)	498 (46.0%)
ADHD	108 (27.9%)	16 (8.5%)	24 (4.7%)	148 (13.7%)
Sleep problems	137 (35.4%)	56 (29.8%)	79 (15.6%)	272 (25.1%)
PTSD	66 (17.1%)	20 (10.6%)	21 (4.1%)	107 (9.9%)
Eating disorder	49 (12.7%)	16 (8.5%)	22 (4.3%)	87 (8.0%)
OCD	59 (15.2%)	15 (8.0%)	8 (1.6%)	82 (7.6%)
Sensory processing disorder	61 (15.8%)	9 (4.8%)	5 (1.0%)	75 (6.9%)
None	34 (8.8%)	48 (25.5%)	219 (43.1%)	301 (27.8%)
Income sufficient for living expenses, *n* (%)	184 (47.5%)	101 (53.7%)	368 (72.4%)	653 (60.3%)
Food insecurity in the past year (Frequently/Sometimes), *n* (%)	182 (47.0%)	97 (51.6%)	154 (30.3%)	433 (40.0%)
Country, *n* (%)				
Argentina	82 (30.7%)	62 (23.2%)	123 (46.1%)	267
Brazil	73 (36.0%)	54 (26.6%)	76 (37.4%)	203
Chile	85 (45.9%)	19 (10.3%)	81 (43.8%)	185
Dominican Republic	1 (50.0%)	0 (0.0%)	1 (50.0%)	2
Mexico	10 (34.5%)	6 (20.7%)	13 (44.8%)	29
Uruguay	60 (30.8%)	24 (12.3%)	111 (56.9%)	195
Venezuela	76 (37.6%)	23 (11.4%)	103 (51.0%)	202

Note: All group differences were statistically significant (χ^2 tests, $p < 0.001$ for categorical variables; one-way ANOVA for age, $p < 0.001$). Total $N = 1,083$ (confirmed autistic $n = 387$, suspected autistic $n = 188$, non-autistic $n = 508$). Percentages for country rows reflect the proportion of each autism group within that country. Sample size varies slightly across variables due to missing responses.

Table 2. Lifetime rates of suicidal ideation and behavior by autism group.

Autism group	Any SI or behavior *n* (%) [95% CI]	Serious ideation or worse *n* (%) [95% CI]	Planning or attempt *n* (%) [95% CI]	Lifetime suicide attempt *n* (%) [95% CI]
Confirmed autistic ($n = 369$)	314 (85.1) [81.1–88.4]	243 (65.9) [60.9–70.5]	166 (45.0) [40.0–50.1]	83 (22.5) [18.5–27.0]
Suspected autistic ($n = 172$)	144 (83.7) [77.5–88.5]	112 (65.1) [57.7–71.8]	69 (40.1) [33.1–47.6]	24 (14.0) [9.6–19.9]
Non-autistic ($n = 438$)	243 (55.5) [50.8–60.1]	128 (29.2) [25.2–33.6]	77 (17.6) [14.3–21.4]	25 (5.7) [3.9–8.3]
Total ($N = 979$)	701 (71.6)	483 (49.3)	312 (31.9)	132 (13.5)

Note: All differences between groups were statistically significant (Pearson χ^2 test, all $p < 0.001$). 95% confidence intervals were calculated using the Wilson score method. SI = suicidal ideation.

a substantial majority of both autistic groups endorsed any suicidal ideation, the largest absolute group differences emerged at the serious-ideation level, roughly a 36-percentage-point gap relative to non-autistic adults, indicating that elevated risk extends well beyond passive or fleeting thoughts.

Binary logistic regression models adjusted for country of residence were used to examine the independent association between autism status and each outcome, with Uruguay as the reference country. Uruguay was selected as the reference category because it contributed a sizable and well-balanced sample and represented the modal non-autistic majority pattern; the authors note this was a pragmatic rather than theory-driven choice. With the Dominican Republic excluded, the models were fit across the six countries with adequate cell sizes, and all were statistically significant at the omnibus level (all $\chi^2(7)$ $p < 0.001$). As shown in Table 3, confirmed autistic adults had substantially elevated odds of every outcome compared with non-autistic adults: any suicidal ideation or behavior (OR = 5.03, 95% CI [3.51, 7.21]), serious suicidal ideation or worse (OR = 4.99, 95% CI [3.65, 6.82]), suicidal planning or attempt (OR = 3.96, 95% CI [2.85, 5.50]), and lifetime suicide attempt (OR = 5.32, 95% CI [3.29, 8.60]). Suspected

Table 3. Adjusted odds ratios (OR) and 95% confidence intervals for autism status across four levels of lifetime suicidal ideation and behavior (reference: non-autistic adults).

Outcome	Confirmed Autistic OR (95% CI)	Suspected autistic OR (95% CI)
Any suicidal ideation or behavior	5.03 (3.51–7.21)***	4.41 (2.75–7.06)***
Serious suicidal ideation or worse	4.99 (3.65–6.82)***	4.93 (3.32–7.31)***
Suicidal planning or attempt	3.96 (2.85–5.50)***	3.44 (2.29–5.16)***
Lifetime suicide attempt	5.32 (3.29–8.60)***	3.49 (1.90–6.42)***

***$p < .001$.

Note: All models adjusted for country of residence (Uruguay as reference). Odds ratios greater than 1 indicate elevated risk relative to non-autistic adults.

autistic adults also showed consistently elevated odds across all outcomes (ORs = 4.41, 4.93, 3.44, and 3.49, respectively, all $p < 0.001$). Nagelkerke R^2 values ranged from 0.152 to 0.228, indicating that autism status and country together explained a meaningful, though moderate, proportion of variance in these outcomes.

Past 12-month intense suicidal ideation

Past 12-month rates of intense suicidal ideation were examined using three binary frequency indicators among participants with complete data ($N = 936$; see Table 4). As operationalized in the SBQ-ASC, 'intense suicidal ideation' refers to serious thoughts about ending one's life, distinct from fleeting or passing thoughts. Rates differed markedly across groups at every frequency level (all Pearson χ^2 $p < 0.001$). Any intense suicidal ideation in the past 12 months was endorsed by 70.0% of confirmed autistic adults, 65.4% of suspected autistic adults, and 33.1% of non-autistic adults. Monthly or more frequent ideation was reported by 42.5%, 35.9%, and 16.0%, respectively; weekly or more frequent ideation by 17.2%, 10.9%, and 4.3%. As with the lifetime data, a clear frequency gradient was evident.

Parallel logistic regression analyses for the three past 12-month outcomes yielded a consistent pattern of elevated risk (see Table 5). Confirmed autistic adults showed substantially elevated odds compared with non-autistic adults for any intense ideation (OR = 5.08, 95% CI [3.69, 6.99]), monthly or more frequent ideation (OR = 3.83, 95% CI [2.72, 5.39]), and weekly or more frequent ideation (OR = 4.58, 95% CI [2.64, 7.96]). Suspected autistic adults showed similarly elevated, though somewhat attenuated, odds across all three outcomes (ORs = 3.95, 2.83, and 2.72, respectively, all $p \leq 0.01$). The wider confidence interval for the suspected autistic group on the weekly ideation outcome (95% CI [1.35, 5.48]) reflects lower precision at this rarer frequency level and should be interpreted with appropriate caution. Hosmer-Lemeshow fit was good across all three models ($p = 0.074$, 0.109, and 0.695 for any-ideation, monthly, and weekly models, respectively). Nagelkerke R^2 values ranged from 0.101 to 0.218.

To examine whether the elevated suicidality observed among adults who suspect they are autistic was attributable to the inclusion of individuals reporting fewer autistic traits, we repeated the country-adjusted models, restricting this group to participants scoring at or above the AQ-10 referral threshold (≥ 6; $n = 69$), while leaving the confirmed-autistic and non-autistic groups unchanged. Relative to non-autistic adults, the restricted autistic-suspected group remained markedly elevated on all four lifetime outcomes, any suicidal ideation or behavior (OR = 9.44, 95% CI [3.64, 24.53]), serious ideation or worse (OR = 5.97 [3.30, 10.81]), planning or attempt (OR = 4.46 [2.53, 7.87]), and lifetime attempt (OR = 4.42 [1.98, 9.83]), and on two of three past-12-month outcomes, any intense ideation (OR = 6.51 [3.39, 12.52]) and monthly or more frequent ideation (OR = 3.49 [1.92, 6.32]). The association with weekly or more frequent ideation was attenuated and no longer significant (OR = 2.46 [0.92, 6.57]), reflecting the small number of events ($n = 6$) in the restricted subgroup. Odds ratios for the confirmed-autistic group were essentially unchanged from the primary analysis.

Hierarchical adjustment for sociodemographic and clinical covariates

To examine whether the elevated odds of suicidality were independent of group differences in sociodemographic and clinical characteristics, we fit three nested logistic regression models for each outcome among participants with complete covariate data ($n \approx 765$; Table 6). Model 1 adjusted for country of residence only; Model 2 added age, gender, education, employment, income sufficiency, and food insecurity; and Model 3 further added eight co-occurring psychiatric conditions (anxiety, depression, ADHD, PTSD, sleep problems, OCD, eating disorder, and sensory processing disorder). Non-autistic adults served as the reference group. In Model 1, the associations were consistent with the primary analysis, with adjusted

Table 4. Frequency Rates of Past 12-Month Intense Suicidal Ideation by Autism Group.

Autism group	Any intense SI *n* (%) [95% CI]	Monthly or more frequent intense SI *n* (%) [95% CI]	Weekly or more frequent intense SI *n* (%) [95% CI]
Confirmed autistic ($n = 360$)	252 (70.0) [65.1–74.5]	153 (42.5) [37.5–47.7]	62 (17.2) [13.7–21.5]
Suspected autistic ($n = 156$)	102 (65.4) [57.6–72.4]	56 (35.9) [28.8–43.7]	17 (10.9) [6.9–16.8]
Non-autistic ($n = 420$)	139 (33.1) [28.8–37.7]	67 (16.0) [12.8–19.8]	18 (4.3) [2.7–6.7]
Total ($N = 936$)	493 (52.7)	276 (29.5)	97 (10.4)

Note. All differences between groups were statistically significant (Pearson χ^2 test, all $p < 0.001$). 95% confidence intervals were calculated using the Wilson score method. SI = suicidal ideation.

Table 5. Adjusted odds ratios (OR) and 95% confidence intervals for autism status across three levels of past-12-month intense suicidal ideation (reference: non-autistic adults).

Outcome	Confirmed autistic OR (95% CI)	Suspected autistic OR (95% CI)
Any intense suicidal ideation	5.08 (3.69–6.99)***	3.95 (2.64–5.92)***
Monthly or more frequent intense SI	3.83 (2.72–5.39)***	2.83 (1.85–4.34)***
Weekly or more frequent intense SI	4.58 (2.64–7.96)***	2.72 (1.35–5.48)**

**$p < 0.01$.
***$p < .001$.
Note. All models adjusted for country of residence (Uruguay as reference). See Results text for estimation and model fit details.

Table 6. Hierarchical logistic regression of suicidal ideation and behavior on autism status, with progressive covariate adjustment (reference category: non-autistic adults).

Outcome	Comparison	Model 1 aOR [95% CI]	Model 2 aOR [95% CI]	Model 3 aOR [95% CI]
Any SI or behavior	Confirmed	5.58 [3.63, 8.56]	4.50 [2.78, 7.28]	3.12 [1.75, 5.55]
	Suspected	5.28 [2.91, 9.58]	4.55 [2.44, 8.48]	3.75 [1.94, 7.24]
Serious SI or worse	Confirmed	5.88 [4.11, 8.40]	4.18 [2.82, 6.20]	2.83 [1.76, 4.54]
	Suspected	5.14 [3.26, 8.11]	4.11 [2.54, 6.65]	3.39 [2.03, 5.64]
Planning or attempt	Confirmed	4.63 [3.22, 6.66]	3.31 [2.23, 4.92]	1.96 [1.24, 3.11]
	Suspected	3.66 [2.33, 5.77]	2.83 [1.75, 4.57]	2.25 [1.36, 3.73]
Lifetime attempt	Confirmed	5.57 [3.40, 9.14]	3.86 [2.26, 6.59]	2.40 [1.32, 4.36]
	Suspected	3.70 [1.99, 6.87]	2.73 [1.43, 5.23]	2.22 [1.13, 4.37]
Any intense SI (12 mo)	Confirmed	5.35 [3.76, 7.63]	3.86 [2.61, 5.71]	2.90 [1.84, 4.57]
	Suspected	5.18 [3.26, 8.23]	4.20 [2.57, 6.85]	3.60 [2.17, 5.95]
Monthly + intense SI	Confirmed	4.51 [3.08, 6.59]	3.15 [2.08, 4.75]	2.19 [1.37, 3.49]
	Suspected	3.37 [2.10, 5.40]	2.60 [1.58, 4.27]	2.16 [1.29, 3.60]
Weekly + intense SI	Confirmed	4.94 [2.70, 9.06]	3.19 [1.66, 6.12]	2.08 [1.02, 4.27]
	Suspected	2.63 [1.20, 5.75]	*2.02 [0.90, 4.55]*	*1.60 [0.69, 3.70]*

Note. aOR = adjusted odds ratio. Reference category = non-autistic adults. Model 1: autism status + country. Model 2: + age, gender, education, employment, income sufficiency, and food insecurity. Model 3: + psychiatric comorbidities (anxiety, depression, ADHD, PTSD, sleep problems, OCD, eating disorder, sensory processing).
Country was adjusted as a fixed effect; the Dominican Republic ($n = 2$) was excluded from the models. Estimates are complete-case (listwise) and based on $n \approx 765$ for lifetime outcomes and $n \approx 764$ for past-12-month outcomes..
All aOR are statistically significant ($p < 0.05$; 95% CI excludes 1) except those shown in italics. Across models the associations attenuate as covariates are added; because several psychiatric comorbidities may lie on the causal pathway between autistic experience and suicidality, Model 3 is interpreted as a conservative lower bound rather than as evidence that the association is spurious.

odds ratios of 4.51–5.88 for confirmed autistic adults and 2.63–5.28 for adults who suspected they were autistic across the seven outcomes. The associations attenuated with successive adjustment: sociodemographic and socioeconomic factors (Model 2) produced only modest attenuation, whereas the addition of psychiatric comorbidities (Model 3) produced larger reductions. In the fully adjusted models, confirmed autistic adults retained 1.96- to 3.12-fold higher odds, and adults who suspected they were autistic 1.60- to 3.75-fold higher odds, of suicidality relative to non-autistic adults. These associations remained statistically significant for every outcome except weekly or more frequent ideation among the autistic-suspected group, for which the fully adjusted estimate was no longer significant (aOR = 1.60, 95% CI [0.69, 3.70]).

The four lifetime and three past-12-month indicators are cumulative thresholds derived from single ordinal items and are therefore nested indicators of increasing severity (or frequency), not independent outcomes. We retain the threshold-specific binary models for clinical interpretability and complement them with models that use the full ordinal structure. For the past-12-month frequency variable, the proportional-odds assumption was supported (test of parallel lines, $p = 0.23$), and a proportional-odds model yielded

cumulative odds ratios of 4.60 (95% CI [3.46, 6.11]) for confirmed autistic and 3.31 [2.32, 4.71] for autistic-suspected adults relative to non-autistic adults. For the lifetime severity variable, the assumption was not supported ($p < 0.001$), so we fit a continuation-ratio model, in which the odds of progressing to a more severe category were 3.07-fold [2.50, 3.77] higher for confirmed autistic and 2.66-fold [2.07, 3.42] higher for autistic-suspected adults. All three strategies (threshold-specific binary, proportional-odds, and continuation-ratio) converged on the same conclusion of substantially and consistently elevated suicidality across the severity and frequency spectrum.

Discussion

The present study examined suicidal ideation and behavior among confirmed autistic, suspected autistic, and non-autistic adults across Latin America. Across both lifetime and past-12-month outcomes, the findings followed a consistent graded pattern, with the highest prevalence among confirmed autistic adults, intermediate prevalence among suspected autistic adults, and the lowest among non-autistic adults. This gradient held at every level of severity, from any suicidal ideation through to lifetime suicide attempt, and was reflected in the country-adjusted models, in which both the confirmed and suspected groups showed elevated odds relative to non-autistic adults across all thresholds. With progressive adjustment for sociodemographic characteristics and co-occurring psychiatric conditions, the magnitude of these elevations attenuated but, for most outcomes, remained statistically significant in the fully adjusted model, which we interpret as a conservative lower bound. The ordinal models, which used the full severity structure of the outcomes, yielded a pattern consistent with the threshold-specific binary models, and the elevation for the suspected autistic group persisted in a sensitivity analysis restricting that group to participants scoring at or above the AQ-10 clinical referral threshold. Taken together, these findings establish elevated suicidality among autistic adults as a robust and graded phenomenon in this Latin American sample, a pattern whose clinical and contextual significance we consider below.

Suicidality in autistic individuals is a complex phenomenon that requires careful and ongoing assessment. Mental health professionals may fail to identify suicidal ideation due to communication and emotional regulation difficulties, anxiety, depression, and camouflaging of autistic traits—all of which can obscure risk and hinder early intervention (Cassidy et al. 2020b; Graham, Rodgers, and Cassidy 2024). In the Latin American countries represented in this study, these clinical challenges are compounded by limited access to specialized mental health services, inadequate public policies, and insufficient professional training (Araripe et al. 2022; Paula et al. 2020; Torres et al. 2021). The high rates of serious suicidal ideation observed among confirmed autistic (66.8%) and suspected autistic adults (63.3%), combined with the finding that nearly half of confirmed autistic adults reported suicidal planning or attempts (45.4%), represent a significant public mental health concern with broad geographical relevance. These findings likely reflect risk trajectories that begin earlier in development, consistent with prior longitudinal and retrospective evidence (Blanchard et al. 2021; Cassidy et al. 2014; Hirvikoski et al. 2020; Schwartzman et al. 2024).

Logistic regression models adjusting for country of residence confirmed that autism status was independently and robustly associated with all four suicidality outcomes (all $p < 0.001$; Table 3). These results align with and extend findings from Newell et al. (2023), whose systematic review and meta-analysis of 40 studies reported prevalence estimates of 34.2% for suicidal ideation, 21.9% for suicide plans, and 24.3% for suicide attempts among autistic adults without co-occurring intellectual disability—albeit with high heterogeneity across studies ($I^2 > 75\%$). Sensitivity analyses showed that excluding participants from the Dominican Republic had a negligible impact on the estimated associations, with autism-status odds ratios differing by no more than 0.05 (Tables 3 and 5). The present findings extend this evidence base to Latin America, a region conspicuously absent from prior reviews. Notably, Cassidy et al. (2018b) demonstrated that autism diagnosis independently accounted for variance in suicidality scores (4.5%; $F(1,324) = 24.9$, $p < 0.001$), as did camouflaging (3.5%; $F(1,139) = 6.56$, $p = 0.01$)—mechanisms likely operating in the present sample as well, though not directly measured.

The autistic and suspected autistic groups also carried a substantially higher burden of co-occurring psychiatric conditions, including anxiety, depression, ADHD, PTSD, and sleep problems, each of which is itself independently associated with suicidality. Part of the elevated risk observed here is therefore likely explained or mediated by these comorbidities, consistent with the attenuation of the autism-status odds ratios when psychiatric conditions were added in the fully adjusted models (Model 3; Table 6). Because the

design is cross-sectional, however, we cannot determine whether co-occurring conditions act primarily as confounders, as mediators on the pathway between autistic experience and suicidality, or both, a distinction that represents an important target for future longitudinal research.

Clinical, policy, and research implications

Taken together, these findings highlight an urgent need to prioritize autism-informed suicide prevention across Latin America. At the clinical level, the consistently elevated risk observed across all four severity levels supports the implementation of routine, mandatory screening for suicidal ideation and behavior in all services providing care to autistic individuals. Such screening should use validated, autism-adapted tools to ensure appropriate detection in a population where social communication differences may obscure risk. Suicide risk assessment should be conceptualized as an ongoing process requiring longitudinal monitoring by trained professionals, rather than a one-time evaluation. When risk is identified, clear and standardized protocols should activate networks of continuous, personalized, and accessible care.

Mental health services must also be adapted to the specific needs of autistic individuals, including accommodating sensory differences within clinical environments and implementing alternative care pathways—such as electronic appointment systems—that reduce barriers associated with social interaction and allow for prioritized access in acute situations. Suicide prevention efforts should extend beyond the individual to include family members and close supports, with psychoeducation on suicidality strengthening their capacity to recognize warning signs and serve as protective factors.

At the policy level, expanding access to timely autism diagnosis across the lifespan remains a critical and urgent priority in Latin America, as unmet diagnostic needs compound mental health risks. Autism should be explicitly incorporated into national mental health and suicide prevention strategies, recognizing this population as a high-risk group requiring tailored approaches. Increased and sustained funding for specialized, inclusive services across all levels of support is essential for equitable care. Workforce strengthening is equally important: training initiatives should extend beyond mental health professionals to include first responders—police officers, firefighters, paramedics, and emergency medicine personnel—who are frequently the first point of contact in crisis situations.

Educational systems represent an additional point of leverage. Integrating autism-specific training within medical, nursing, psychology, and allied health university programs can improve early detection, strengthen referral pathways, and enhance the quality of care across the lifespan. This is particularly critical in contexts where underdiagnosis and limited specialized training remain pervasive.

Finally, these findings point to several priorities for future research. Longitudinal studies are needed to characterize the developmental trajectories and predictors of suicide risk among autistic individuals in Latin American settings. Rigorously designed trials are required to evaluate the effectiveness of autism-informed prevention and intervention approaches. Further validation of suicide risk assessment tools, including the SBQ-ASC, is needed to ensure cultural appropriateness beyond language translation. While advancing this research agenda will ultimately inform evidence-based clinical guidelines, the development of preliminary policies and investment in services should not await this evidence—rather, future research will provide guidance on how best to optimize investments that are already imperative for public health and social justice.

Limitations

Several limitations warrant consideration. First, the cross-sectional design precludes causal inference or conclusions about temporal sequencing between autism status and suicidality. Second, the suspected autistic group was defined by self-identification alone, without formal diagnostic confirmation, and elevated suicidality in this group may partly reflect co-occurring conditions—such as ADHD, personality disorders, or mood disorders—rather than autistic traits per se. Although AQ-10 scores confirmed that suspected autistic adults occupy a statistically distinct intermediate position on the autistic trait continuum ($M = 4.94$, SD = 2.12; F(2, 1004) = 464.79, $p < 0.001$, $\eta^2 = 0.48$), only 38.3% scored at or above the clinical referral threshold of 6, and a sensitivity analysis restricting the group to those scoring at or above the threshold confirmed that the elevated suicidality was not attributable to the inclusion of lower-scoring individuals (Supplementary Table S2). Third, several important confounds were not measured, including executive functioning difficulties, barriers to mental health care access, and camouflaging or masking. Fourth, generalizability is substantially limited by the sampling approach. Recruitment through the REAL

advocacy network *via* online channels systematically favors individuals with digital access and community engagement; more than 58% of participants reported university-level education—well above the 15–30% regional average (UNESCO, UNICEF, and ECLAC 2022)—women were overrepresented (73.4%), and autistic adults with intellectual disability were necessarily excluded by the design of the SBQ-ASC. These findings should therefore be interpreted as reflecting suicidality patterns within a relatively educated and advocacy-connected stratum of Latin American autistic adults rather than as population-representative estimates. Importantly, this study is among the first to examine autism and suicidality in Latin America, where no published research currently exists on this topic. Collectively, these limitations highlight the need for future research using longitudinal designs, structured diagnostic assessments, and community-based sampling strategies.

Conclusion

This study provides the first multi-country evidence on suicidality among autistic adults in Latin America, documenting rates of lifetime and past-year suicidal ideation and behavior that are comparable to or higher than those reported in high-income countries—and that remain robustly elevated across all severity levels after adjusting for country of residence. Both confirmed and suspected autistic adults showed odds of suicidality three to six times higher than their non-autistic peers, a pattern that was strikingly consistent across seven diverse national contexts differing in mental health infrastructure, economic conditions, and diagnostic capacity.

These findings provide preliminary evidence, based on a non-probability online sample, of elevated suicidality among diagnosed and self-identified autistic adults recruited from several Latin American countries. Although this pattern was consistently observed across the countries included in the study, future research using representative samples and multivariable analytical approaches is needed before robust cross-national inferences can be drawn.

The evidence presented here makes clear that autism-informed suicide prevention can no longer be deferred in Latin America. What is needed is not simply more research, but immediate and coordinated action: routine suicidality screening using validated autism-adapted tools, expanded access to timely diagnosis and culturally responsive mental health care, and sustained investment in workforce training across clinical, educational, and emergency response settings. Autistic adults in Latin America deserve the same level of evidence-based protection afforded to their counterparts in high-income countries—and this study provides both the justification and the foundation for that work to begin.

Disclosure statement

No potential conflict of interest was reported by the authors.

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