Open Access Library Journal
2026, Volume 13, e15008
ISSN Online: 2333-9721
ISSN Print: 2333-9705

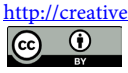
The Nest to Arc Theory of Neurodivergent Grief

Julius M. Jefferies

Department of Clinical Mental Health (Independent Practice), Knoxville, TN, USA
Email: jefferiesjulius@gmail.com

How to cite this paper: Jefferies, J.M. (2026) The Nest to Arc Theory of Neurodivergent Grief. *Open Access Library Journal*, **13**: e15008.
https://doi.org/10.4236/oalib.1115008

Received: February 9, 2026
Accepted: March 17, 2026
Published: March 20, 2026



Abstract

This manuscript presents the NEST to ARC Theory of Neurodivergent Grief grounded in fourteen years of doctoral level clinical practice, longitudinal observation and research synthesis across outpatient psychotherapy, crisis intervention, consultation liaison work and end of life care. Neurodivergent individuals often grieve within nervous systems shaped by chronic sensory, load executive function strain, social exclusion and cumulative trauma exposure. Across clinical settings, a reproducible pattern is observed when grief is treated using neurotypical assumptions, particularly exposure forward protocols delivered without neurodivergent titration skills, only cognitive behavioral variants that underaddress attachment and meaning, and metaphor forward narrative approaches that over rely on interpretive abstraction. Many clients demonstrate symptom escalation, functional regression, care dropout and subsequent treatment intensification. Persistent Autistic Burnout [1] is conceptualized as a load bearing moderator that narrows oscillation bandwidth, the safe capacity to move between loss oriented processing and restoration oriented functioning [2] without prolonged threat physiology. Prolonged grief is reframed as a predictable outcome of failure of fit misalignment between nervous system needs and environmental or treatment demands rather than an individual pathology. NEST Neuroception Executive scaffolding Sensory accommodation Titration restores regulatory capacity, while ARC Attachment Rituals and Rights Community and Communication restores relational inclusion legitimacy and meaning. A pragmatic differential diagnosis pathway is offered to distinguish prolonged grief disorder complex PTSD major depression and dissociation or psychosis like phenomena using measures such as PG 13 R and the International Trauma Questionnaire. A multi phase research and implementation agenda is proposed alongside ethical recommendations to reduce preventable harm.

Subject Areas

Clinical Psychology

Keywords

Neurodivergent Grief, Autism, ADHD, Prolonged Grief Disorder, Complex PTSD, Autistic Burnout, Iatrogenic Harm, Overmedication, Quality of Life, Trauma Informed Care

1. Introduction, and Approach to Synthesis

Over fourteen years of clinical practice, consistent and reproducible patterns have emerged in the treatment of neurodivergent individuals experiencing grief. These patterns transcend setting age and presenting complaint. When grief occurs in autistic and ADHD adults [3], it is frequently misunderstood, misdiagnosed and mistreated, not due to lack of intervention, but due to foundational mismatches between neurotypical treatment assumptions, and neurodivergent nervous systems. Across cases, a common trajectory recurs: loss occurs, standard grief or trauma protocols are applied, symptoms escalate, medications are added and functioning declines, and the individual is labeled resistant avoidant or complex. The NEST to ARC Theory emerged from the ethical imperative to interrupt this cycle, and to provide a neurodivergent first framework that is precise enough to guide clinical decisions, and measurable enough to be tested.

Approach to Synthesis

This manuscript integrates practice based evidence with peer reviewed literature to address a persistent gap neurodivergent adults are often underrepresented in bereavement, and trauma treatment trials leaving clinicians to extrapolate from neurotypical samples. Practice based evidence was derived from clinical work across outpatient therapy crisis response consultation interfaces, and end of life grief care.

Clinical observations were documented through three primary channels. First routine outcome tracking when feasible including symptom severity ratings functional stability markers, and client reported tolerability of interventions. Second structured case note coding using consistent tags for regulatory collapse shutdown, or meltdown executive function failure sensory overload dissociation, or psychosis like phenomena, and treatment mismatch patterns such as post session functional regression. Third supervision, and peer consultation review emphasizing pattern replication across clinicians, and settings, and separating idiosyncratic cases from recurrent trajectories.

The literature synthesis used pragmatic weighting. Consensus clinical guidance, and validated measures were weighted highly systematic reviews, and meta analyses were prioritized when available adult autism data were preferred over pediatric only samples for prescribing, and functional outcomes, and when autism specific grief data were absent adjacent evidence such as burnout camouflaging, and polypharmacy research was used cautiously, and labeled as inference rather

than settled conclusion.

2. Baseline Load, and Core Constructs

Baseline Load as a Clinical Phenotype

In practice baseline load presents not simply as historical adversity, but as a lived physiological condition. Many autistic, and ADHD adults enter grief episodes with constrained sleep stability elevated sensory vigilance chronic digestive, or pain complaints, and limited margin for administrative demand. The clinical implication is that the same bereavement event carries a different dose depending on preexisting load. A brief increase in responsibilities that might be tolerable for a neurotypical person can precipitate shutdown for a neurodivergent person who is already operating near the edge of capacity. Baseline load is therefore assessed not only by trauma history, but by current allostatic strain including sleep variability stimulant, or sedative rebound cycles conflict exposure, and ongoing camouflaging demands.

Clinicians can document baseline load using a functional snapshot at intake, or at the onset of bereavement. Recommended domains include sleep duration, and fragmentation meal regularity sensory triggers, and recovery time weekly meltdown, or shutdown frequency social demand hours per day, and executive burden such as paperwork caregiving, or work quotas. This snapshot becomes the comparator for detecting iatrogenic regression.

Neurodivergent grief occurs within baseline load. Autistic adults experience disproportionately high exposure to adverse life events [4] including bullying social exclusion employment instability healthcare invalidation [5], and institutional betrayal. Quality of life findings consistently show lower life satisfaction higher unemployment increased medical comorbidity [6], and elevated suicide risk [7] compared with neurotypical peers. These disparities are best explained not by autism per se, but by cumulative environmental stressors, and systemic exclusion.

To prevent abstraction the NEST to ARC model defines three core constructs operationalized for clinical, and research utility.

Persistent Autistic Burnout is defined as a prolonged state of exhaustion, and increased disability arising from chronic stress, and insufficient accommodation. Operational markers include sustained exhaustion lasting months measurable loss of skills, or functional capacity reduced tolerance to sensory, and social demands, and increased shutdown or meltdown frequency.

Oscillation bandwidth is the individual's safe, and reversible capacity to move between loss oriented processing contact with grief cues memory longing meaning, and restoration oriented functioning tasks roles routines forward living without triggering prolonged threat physiology such as shutdown panic dissociation rage, or suicidality. Oscillation bandwidth can be tracked by recovery time after grief contact degree of post session functional impairment frequency of dissociation, or shutdown following loss cues, and ability to re enter routines within 24 to 72 hours.

Failure of fit refers to a systemic mismatch wherein the demands of environment, or treatment exceed available regulatory resources producing predictable deterioration misattributed to resistance. Operational indicators include symptom escalation temporally linked to intervention delivery functional regression following standard protocol steps increased medication escalation, or service utilization after treatment failure, and improvement when sensory, and executive accommodations, and titration are implemented.

Clinically Persistent Autistic Burnout often includes a paradoxical combination of heightened sensitivity, and reduced output. Clients may describe their world as louder brighter more chaotic while simultaneously feeling unable to initiate tasks they previously managed. Observable markers include increased cancellation, or late arrival due to preparation fatigue diminished tolerance for interpersonal ambiguity reduced ability to mask, and a rise in rigid routines that function as emergency regulation rather than preference. Because burnout is frequently misread as depression, or oppositionality the operational definition above is paired with collateral data such as skill loss, and sensory intolerance that are not fully explained by depressed mood alone.

3. Differential Diagnosis Clarification, and Decision Pathway

Measurement Anchored Decision Points

A measurement anchored pathway improves reliability across clinicians, and reduces diagnostic overshadowing. PG 13 R can be used as a primary indicator [8] of prolonged grief severity, and functional impairment. The International Trauma Questionnaire can be used [9] to identify PTSD, and CPTSD domains including disturbances in self organization. When both measures are elevated clinicians should conceptualize a blended grief trauma presentation, and prioritize NEST stabilization before any intensive grief exposure.

When depressive symptoms appear prominent a practical clinical test is whether the client retains capacity for momentary pleasure, or interest outside the loss. In prolonged grief the capacity for interest may remain, but is constrained by yearning, and preoccupation whereas major depression tends toward global anhedonia, and self devaluation. When dissociation, or psychosis like phenomena are present state dependence becomes a key discriminant. Symptoms that intensify under sleep deprivation sensory overload, or high demand, and diminish with accommodation are more consistent with overload, and trauma physiology than a primary psychotic disorder. Safety remains paramount, and persistent loss of reality testing requires urgent psychiatric evaluation regardless of etiology.

Neurodivergent grief may present with shutdown identity destabilization, and perceptual anomalies that can be misread as primary mood, or psychotic disorders. Diagnostic precision supports safer intervention selection.

Prolonged Grief Disorder is typically organized around persistent yearning longing, or preoccupation with the deceased identity disruption related to the loss, and functional impairment extending beyond expected time course. The PG 13 R

provides a structured assessment of symptom severity, and impairment.

Complex PTSD in the ICD 11 framework [10] involves PTSD symptoms plus disturbances in self organization affect dysregulation negative self concept, and relational disturbance. The International Trauma Questionnaire supports differentiation of PTSD, and CPTSD domains.

Major Depressive Disorder is characterized by pervasive anhedonia low mood guilt, or worthlessness, and neurovegetative change not primarily organized around separation distress. Grief, and depression can co occur the differential emphasis is on separation yearning versus global anhedonia, and self critical cognitions.

Dissociation, and psychosis like phenomena such as derealization depersonalization intrusive imagery perceptual distortions, or fixed catastrophic beliefs may emerge under severe load sleep disruption, or burnout. These experiences require careful assessment for safety duration, and reality testing, and may be state dependent.

Decision pathway. Step 1 if distress is organized around separation yearning, and preoccupation administer PG 13 R. Step 2 if trauma symptoms, and disturbances in self organization are present administer the International Trauma Questionnaire. Step 3 if global anhedonia pervasive self criticism, and neurovegetative change predominate assess depression severity, and suicidality. Step 4 if dissociation, or psychosis like features are present determine state dependence stabilize sleep sensory load, and executive demands first, and seek urgent psychiatric evaluation when reality testing is persistently impaired, or risk escalates.

4. Neurotypical Treatment Mismatch Specific Protocol Families, and Adaptations

Practical Titration Protocol for Neurodivergent Grief Sessions

A practical titration protocol can be implemented regardless of theoretical orientation. The clinician establishes a baseline safety routine at the start of session including predictable agenda consent reminders, and a brief sensory check. The clinician then selects a single grief contact target such as one memory one object one location, or one administrative task. Contact is time boxed, and paired with an explicit return to regulation. The clinician tracks three variables in real time autonomic activation level functional clarity, and recovery speed. If activation rises without recovery within minutes the dose is reduced immediately. The clinician ends the session only after recovery has occurred, and the client can describe at least one restoration task they can complete safely within the next day.

In session alternatives to metaphor include concrete scaffolds such as timelines lists maps, and sensory descriptions. For many clients meaning emerges after regulation rather than before it. Therefore, clinicians should treat interpretation as an outcome not a demand. The adapted stance is not less depth, but different sequencing safety then contact then integration.

Dominant grief, and trauma treatments often assume metaphor fluency sustained interoceptive focus rapid emotional labeling, and baseline regulatory re-

serve. For many autistic clients these assumptions do not hold. When deterioration occurs, it is commonly misinterpreted as avoidance, or resistance prompting escalation rather than recalibration.

Intervention families commonly associated with mismatch include exposure forward PE derived protocols delivered without neurodivergent titration skills only CBT variants that treat grief primarily as cognition correction without attachment, and meaning restoration, and metaphor forward narrative approaches that place interpretive pressure on clients who process literally.

Exposure forward protocols. Contraindicated elements under low oscillation bandwidth include prolonged in session flooding limited choice points high interoceptive demand stay in it until it drops rules, and therapist driven pacing. Neurodivergent adapted alternatives emphasize micro titrated contact with loss cues frequent autonomic breaks explicit consent to pause, or stop, and structured pendulation between loss, and restoration tasks within session.

Skills only CBT variants. Contraindicated elements include compliance heavy homework without executive scaffolding invalidation of sensory realities as mere distortions, and rapid pacing that assumes intact working memory during bereavement. Neurodivergent adapted alternatives integrate externalized planning single step behavioral targets, and sensory accommodation as core interventions rather than optional add ons.

Metaphor forward narrative approaches. Contraindicated elements include interpretive demand pressure to translate grief into metaphor, and assumptions of emotional labeling fluency. Neurodivergent adapted alternatives privilege concrete meaning making using timelines facts sensory memory anchoring, and non performative expression.

Titration implementation is dose control. In session practices include time boxed grief contact such as 2 to 6 minutes regulated return to baseline stop signal agreements interoceptive breaks movement grounding sensory tools, and a session end rule that avoids termination at peak activation. Homework is delivered as micro doses one cue one minute one recovery practice tracked rather than assumed.

5. The Nest to Arc Model Clinician Actions, and Measurable Indicators

Suggested Indicator Set for Routine Outcome Tracking

To support reproducibility clinicians can track a small indicator set weekly. Suggested indicators include PG 13 R score ITQ domains sleep stability rating recovery time after grief contact number of shutdown, or meltdown episodes per week, and a functional participation marker such as hours of work school, or community engagement. In addition, a medication burden snapshot can be recorded including number of psychotropic agents, and notable side effects that affect cognition appetite, or sleep.

Oscillation bandwidth can be quantified pragmatically by documenting the client's ability to shift from loss oriented content to restoration oriented tasks within

the same session, and to resume daily routines within a defined window. A simple charting method is to record whether the client returned to baseline within session, and whether there was next day functional regression. Over time increased bandwidth should appear as faster recovery fewer shutdowns, and higher participation despite ongoing grief.

NEST restores intrapersonal regulatory capacity, and protects oscillation bandwidth. ARC restores relational inclusion legitimacy, and meaning. Each component is mapped to concrete clinician actions, and measurable indicators.

N Neuroception. Actions include explicit consent predictable session structure literal language collaborative agenda setting, and co created stop signals. Indicators include reduced panic cues improved session engagement, and reduced post session regression.

E Executive scaffolding. Actions include externalized planning scripts single variable homework reminders, and support for restoration tasks such as paperwork housing transitions, and medical decision making. Indicators include improved follow through fewer missed appointments improved ADLs, and measurable vocational steps.

S Sensory accommodation. Actions include modifying lighting, and sound permitting movement, and stimming integrating sensory recovery breaks, and planning for sensory hazards in hospitals funerals, and workplaces. Indicators include reduced shutdown frequency improved sleep reduced irritability, and lower somatic overload.

T Titration. Actions include micro dosed contact with loss cues timed exposure pendulation between loss, and restoration, and ending sessions only after return to regulation. Indicators include shorter recovery time decreased dissociation expanded oscillation bandwidth, and reduced crisis spikes.

A Attachment. Actions include stabilizing supports teaching literal validation repairing ruptures, and incorporating non human attachment supports when clinically appropriate. Indicators include reduced isolation improved help seeking, and improved relational safety.

R Rituals, and Rights. Actions include creating concrete rituals addressing disenfranchised grief, and protecting the right to grieve without performance. Indicators include reduced shame improved coherence, and increased participation in chosen remembrance practices.

C Community, and Communication. Actions include psychoeducation to reduce the double empathy gap communication supports, and advocacy for workplace school, and healthcare accommodations. Indicators include fewer invalidation events improved stability reduced dropout, and improved community participation.

6. System Design the Adult Cliff, and Global Comparisons

Policy Levers that Protect Bandwidth during Bereavement

Several policy levers function as clinical interventions at scale. Bereavement leave

that is flexible in timing, and allows intermittent use supports titration by preventing forced exposure to high demand environments. Simplified benefits recertification reduces executive overload. Sensory, and communication accommodation standards in hospitals courts, and workplaces reduce neuroceptive threat. Coordinated care pathways that include grief trauma, and neurodivergence expertise prevent misdiagnosis, and reduce crisis utilization. From a prevention perspective these levers should be evaluated by their capacity to reduce secondary crises such as housing instability job loss, and legal complications that commonly follow bereavement.

Bereavement is a system stressor involving funerals paperwork housing transitions employment interruption medical decision making, and caregiver change. Restoration tasks become trauma triggers when systems are inaccessible. In fragmented systems adult services may be discontinuous, and administrative burden rises precisely when executive capacity is compromised. Within NEST to ARC these are active mechanisms that compress bandwidth, and increase CPTSD, and prolonged grief risk.

International comparisons suggest that systems that reduce administrative burden ensure sensory, and communication accommodation, and protect stability during bereavement reduce risk that grief escalates into chronic threat. Conversely systems that increase burden unpredictability, and service discontinuity increase functional collapse risk. These observations motivate multinational validation studies that treat system variables as moderators rather than background context [11].

7. Iatrogenic Harm, and Medication Escalation Separating Patterns Mechanisms, and Evidence

Clinical Safeguards to Reduce Iatrogenic Risk

A central safeguard is temporal attribution. When symptom escalation, or functional regression closely follows a treatment step clinicians should treat the intervention as a plausible contributor, and adjust accordingly. Safeguards include documenting baseline functioning before protocol changes using brief side effect check ins that include cognition, and sleep, and scheduling follow up contacts after high intensity sessions to detect delayed shutdown.

A second safeguard is dose transparency. Clients benefit from explicit explanation that therapeutic dose includes sensory demand cognitive demand emotional demand, and social demand. A session can be emotionally gentle, but sensory, or executive toxic. Naming these dimensions improves consent, and collaboration, and reduces shame when clients cannot comply with standard homework expectations.

This section strengthens causal language by separating observed clinical patterns from hypothesized mechanisms, and existing empirical support.

Observed clinical patterns practice based evidence. In some neurodivergent grief cases treatment mismatch is followed by post session functional regression

increased shutdowns higher dissociation increased crisis utilization, and medication intensification including polypharmacy. Clients may report reduced interoceptive clarity increased fatigue, and cognitive slowing that interfere with grief integration, and restoration task completion. These patterns are presented as recurrent observations not universal claims.

Hypothesized mechanisms testable. Mechanisms include threat physiology amplification when exposure is delivered without accommodation signal distortion when sedating, or cognitively blunting regimens reduce outward distress while impairing sleep learning, and meaning making, and diagnostic overshadowing when shutdown sensory overwhelm, or trauma reactions are misclassified as primary psychosis, or treatment resistance.

Existing empirical support. Studies, and reviews document substantial psychotropic medication use and polypharmacy in autistic adults, and emphasize limited adult specific evidence for many prescribing decisions. Known adverse effect profiles of antipsychotics antidepressants, and sedatives reinforce the need for shared decision making, and functional outcome monitoring particularly when grief related burnout, and sensory overload are present [12]-[16].

8. Proposed Research and Implementation Agenda

Training and Fidelity Metrics

Implementation requires that NEST to ARC be teachable, and auditable. Training modules should include sensory accommodation competencies literal communication skills executive scaffolding techniques, and titration fidelity. Fidelity can be monitored through session checklists that record whether consent, and stop signals were used whether grief contact was time boxed whether recovery occurred before session end, and whether a restoration task plan was created. These metrics can be used for supervision quality improvement, and research replication without reducing clinical flexibility.

A multi phase research program is required to validate NEST to ARC, and quantify mechanisms.

Phase I descriptive, and epidemiological studies examining grief prevalence CPTSD onset burnout trajectories camouflaging burden, and quality of life outcomes in autistic, and ADHD adults. Batteries should pair PG 13 R, and the International Trauma Questionnaire with functioning markers work education participation independent living capacity, and system variables time to care administrative burden, and accommodation availability.

Phase II manualized pragmatic trials comparing NEST to ARC to enhanced usual care with primary outcomes PG 13 R, and ITQ scores functional stability dropout rates, and post session regression markers.

Phase III three to five year longitudinal follow up assessing durability of gains employment stability healthcare utilization medication burden, and suicide risk.

Phase IV implementation science, and policy translation including workforce training modules titration fidelity metrics, and system redesign recommendations

that reduce administrative burden, and improve sensory, and communication accessibility.

9. Ethical Implications Clinical Summary, and Recommendations

Ethical Reflection across Fourteen Years

Across fourteen years, a striking ethical pattern is that harm often arises not from malice, but from default assumptions. Clinicians may over value emotional catharsis under value regulation, and treat neurodivergent needs as preferences rather than access requirements. This leads to quiet coercion, and the client must perform grief in an approved format to be considered engaged. The ethical alternative is to treat the nervous system as the primary context, and to judge progress by functional stability, and meaning integration rather than by visible affect.

Another repeated theme is the moral injury experienced by neurodivergent clients when they are repeatedly blamed for treatment failure. Being labeled resistant avoidant, or manipulative after deterioration can itself become a trauma event that compounds grief. Ethical documentation should therefore avoid pejorative inference, and instead describe observable process variables such as overwhelm shutdown dissociation, and dose mismatch. This protects clients in multidisciplinary contexts including medical systems disability reviews, and legal settings.

Clinical recommendations for ethical practice include building accommodation into the default workflow not as an exception. Clinics can standardize sensory friendly spaces provide written agendas use predictable scheduling, and offer asynchronous communication options. At the systems level ethics requires training pipelines to include neurodivergence grief, and trauma physiology as core competencies.

Across fourteen years of doctoral level clinical practice the most ethically salient pattern has not been the presence of grief in neurodivergent lives, but the predictable injury that occurs when care systems treat neurodivergent nervous systems as if they were neurotypical. Symptom escalation, and functional regression are often not signs of noncompliance, but signals that intervention dose assumptions, and environment exceeded available oscillation bandwidth. When those signals are ignored grief can be converted into preventable trauma an outcome that must be framed as an ethical failure not merely a clinical challenge.

Nonmaleficence requires active prevention of foreseeable mismatch harm. When repeated post session regression increased shutdown rising dissociation, or escalating suicidality follow protocol steps the ethical response is recalibration not escalation. Informed consent is incomplete when clients are not told that certain protocol families can be destabilizing without accommodation, and that pacing alternatives exist.

Justice requires equivalent effectiveness not procedural sameness. Delivering the same manuals at the same pace with the same interpretive demands in populations excluded from many trials is not equity. Ethical care must include sensory

access literal communication executive scaffolding, and titration that respects bandwidth.

A second ethical theme is epistemic injustice neurodivergent clients are frequently disbelieved when they report that a treatment step worsened functioning. Treating these reports as data rather than defiance is both clinically effective, and ethically required.

Recommendations for practice. Lead with regulation before interpretation. Titrate grief contact with time boxing pendulation, and recovery based session endings. Use PG 13 R, and the International Trauma Questionnaire alongside functional indicators including sleep ADLs, and recovery time to track oscillation bandwidth. Coordinate with prescribers using functional outcome monitoring, and avoid substituting medication for accommodation, and scaffolding. Include ARC elements explicitly by building rituals protecting grief rights repairing attachment, and educating supporters to reduce disenfranchisement, and the double empathy gap.

Clinical conclusion. Neurodivergent individuals do not fail grief treatment, treatment frequently fails neurodivergent individuals when it is delivered with neurotypical assumptions and performance demands. NEST to ARC offers a corrective path by restoring bandwidth and rebuilding belonging. Grief will always hurt. What must end is avoidable harm produced by care systems that refuse to fit the nervous system they serve.

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Raymaker, D.M., Teo, A.R., Steckler, N.A., Lentz, B., Scharer, M., Delos Santos, A., *et al.* (2020) "Having All of Your Internal Resources Exhausted Beyond Measure and Being Left with No Clean-Up Crew": Defining Autistic Burnout. *Autism in Adulthood*, **2**, 132-143. https://doi.org/10.1089/aut.2019.0079

[2] Stroebe, M. and Schut, H. (2010) The Dual Process Model of Coping with Bereavement: A Decade on. *OMEGA—Journal of Death and Dying*, **61**, 273-289. https://doi.org/10.2190/om.61.4.b

[3] Lord, C., Elsabbagh, M., Baird, G. and Veenstra-Vanderweele, J. (2018) Autism Spectrum Disorder. *The Lancet*, **392**, 508-520. https://doi.org/10.1016/s0140-6736(18)31129-2

[4] Kerns, C.M., Newschaffer, C.J. and Berkowitz, S.J. (2015) Traumatic Childhood Events and Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, **45**, 3475-3486. https://doi.org/10.1007/s10803-015-2392-y

[5] Association of American Medical Colleges (2022) Exploring Barriers to Mental Health Care in the United States.

[6] OECD (2023) 2024 Disability Work and Inclusion. OECD Publishing.

[7] Hedley, D. and Uljarevic, M. (2018) Systematic Review of Suicide in Autism Review. *Journal of Autism and Developmental Disorders*, **5**, 121-134.

[8] Prigerson, H.G., Boelen, P.A., Xu, J., Smith, K.V. and Maciejewski, P.K. (2021) Vali-

dation of the New DSM-5-TR Criteria for Prolonged Grief Disorder and the pg-13-Revised (pg-13-r) Scale. *World Psychiatry*, **20**, 96-106. https://doi.org/10.1002/wps.20823

[9] International Trauma Questionnaire ITQ Documentation and Scoring Guidance International Trauma Consortium.

[10] Cloitre, M., Shevlin, M., Brewin, C.R., Bisson, J.I., Roberts, N.P., Maercker, A., *et al.* (2018) The International Trauma Questionnaire: Development of a Self-Report Measure of ICD-11 PTSD and Complex PTSD. *Acta Psychiatrica Scandinavica*, **138**, 536-546. https://doi.org/10.1111/acps.12956

[11] Australian Government Department of Health and Aged Care (2025) National Autism Strategy 2025 to 2031.

[12] Yoshida, K., *et al.* (2023) Prevalence of Psychotropic Medication Use and Psychotropic Polypharmacy in Autistic Adults with or without Intellectual Disability. *Journal of Autism and Developmental Disorders*, **55**, 457-471.

[13] Carthy, E., *et al.* (2016) Psychotropic Medication Prescribing in People with Autism Spectrum Disorders with and without Psychiatric Comorbidity. *BJPsych Advances*, **29**, 131-140.

[14] Lopes, L.P.N., de Oliveira, J.C., Bergamaschi, C.d.C., Fulone, I., Lima, E.d.C., Abe, F.C., *et al.* (2023) Use of Second-Generation Antipsychotics in Autism Spectrum Disorder: A Systematic Review and Meta-Analysis Protocol. *BMJ Open*, **13**, e069114. https://doi.org/10.1136/bmjopen-2022-069114

[15] McCarthy, J.M. and Chaplin, E. (2022) Adults with Intellectual Disability and Autism Spectrum Disorder: What Is the Evidence around the Use of Polypharmacy. *International Journal of Environmental Research and Public Health*, **19**, Article No. 15974. https://doi.org/10.3390/ijerph192315974

[16] National Institute for Health and Care Excellence (2012) Reviewed 2025 Autism Spectrum Disorder in Adults Diagnosis and Management CG142.

Appendix: Practice Ready Clinical Tools

A Brief session structure. Begin with neuroception, and sensory check. Confirm consent, and stop signals. Review one restoration task goal. Select one grief contact target. Time box contact. Return to regulation. Confirm recovery. Create a micro plan for the next 24 hours, including a sensory recovery window, and one manageable task.

B Documentation template. Record baseline load sleep sensory triggers executive burden. Record dose variables sensory demand cognitive demand emotional demand social demand. Record whether recovery occurred before session end, and whether next day regression was present. Record measures PG 13 R, and ITQ when used, and functional indicators such as ADLs, and participation.

C Crisis escalation. When suicidality intensifies, or reality testing is persistently impaired, prioritize safety, stabilize environment, reduce sensory load, contact supports, and coordinate urgent psychiatric evaluation. NEST to ARC is not a substitute for emergency care it is a framework for preventing avoidable escalation.