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Autism Spectrum Australia

Perinatal meltdown and shutdown tip sheet for clinicians

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Introduction

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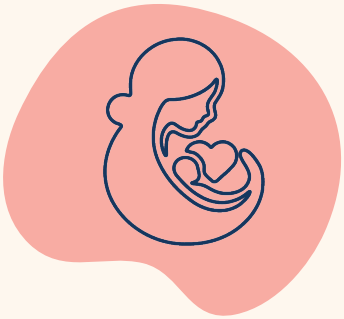
The cascade from sensory overwhelm to meltdown and/or shutdown is poorly understood but practitioner response to any of these can be the defining difference between a neuro-affirming birth and a traumatic experience. Meltdowns and shutdowns are usually not predictable and for many who do not have a diagnosis prior to pregnancy, this may be the first time they have experienced either; it is likely that neither the woman/pregnant person nor their support person will be able to explain what is happening to them. Not ony can meltdowns and shutdowns be embarrassing and scary for your patients, these are also times when procedures or internal examinations might be initiated without consent. During a shutdown, this can occur when the lack of verbal refusal is taken as a form of consent; during a meltdown, one may misjudge what is causing the distress and touch the individual in a way that is unwanted or they are not ready for.



Definitions – What's the difference?

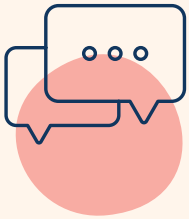
It can be helpful to see a meltdown as an outward response and a shutdown as an inward response to overwhelm. A person's ability to think, process and make decisions is impacted during a meltdown or shutdown.

Meltdown: "becoming completely overwhelmed by the current situation and expressing this verbally (e.g. shouting, screaming, crying) or physically (e.g. kicking, lashing out, biting)" (*Hampton* 2024). Meltdowns can include self-injurious behaviours.

Shutdown: "withdrawing from the world around oneself, for example being unable to communicate, lying down and being completely still and not being able to move" (*Hampton* 2024).

It is best to talk with an Autistic patient about what a supportive response looks like for them before they experience a meltdown or shutdown while in your care.

- What do you anticipate might trigger a meltdown or a shutdown? Is it:
  - pain
  - trauma history
  - sensory demands
  - fear
  - uncertainity
  - waiting too long
  - too many questions?
- What are some warning signs?
- What strategies might mitigate those potential triggers?
- What does a meltdown look like for you?
- What does a shutdown look like for you?
- Who do you trust to make decisions for you if you are unable to?
- What is your preferred communication method if we need to ask you something during and after a meltdown or shutdown?
- Are there any particular activities, interests, or objects that you find soothing after experiencing a meltdown or shutdown? How could we support you to access those things?



Clinical response to a meltdown or shutdown based on neuro-affirming perinatal care

1. **Remove sensory input and demands as much as possible**
   - Take everything out of the situation (lights, sounds, questions) *extinguish everything*
   - Reduce interactions with the individual
   - Avoid physical contact
   - Remove people in the room who are not necessary (except for a trusted clinician or support person)
   - For the people staying in the room, move yourself and any objects (e.g., machines) in a calm manner, without rushing or using sudden movements

2. **Reassure the individual**
   - Keep calm
   - Acknowledge the response – validation can help the individual feel seen and supported

3. **Communicate clearly**
   - Allow extra processing time
   - Use direct language (avoid fluffy language)
   - Offer written instructions or visual instructions incase verbal communication is not effective
   - Communicate with compassion
   - Avoid unnecessary communication and questions

4. **Understand that an individual's threshold for further disruptions may be lowered after a meltdown or shutdown**

5. **If someone has a support person, allow their support person to guide the response to sensory input and demands as much as possible**

Debrief and document

After, take time to debrief with the individual (when they are ready) and any involved support people. Ask what felt helpful or unhelpful from their perspective. Remove their shame by using affirming language. Then, document those insights clearly and respectfully in the person's file or care plan. This creates a record that helps other clinicians understand what works, what to avoid, and how to support the person more effectively in the future. Self-injury may have occurred during the meltdown. If this is the case, discuss referral to other services during the debrief.

Hearing from advisors – What do you need during a meltdown or shutdown?

Sensory preferences

- I needed the lights to be completely turned off.
- I needed all sound to be removed or minimised as much as possible – sound in the room and outside in the corridor, when possible.
- I needed you not to come in with a flashlight.
- I needed not to be physically touched unless absolutely necessary – and if it was necessary, I needed to be told first.
- I needed people to understand: don't hug me.
- I wanted unobtrusive support to help me access sensory input that felt soothing or helpful to me.
- I appreciated the adjustments that were made afterwards, like moving me to a single room and recognising how overstimulating the shared space was.

Communication and advocacy preferences

- I needed people to avoid asking me questions unless it was absolutely life or death.
- I needed a reduction of demands, like requesting a signature on a form, unless absolutely necessary.
- I needed my midwife to advocate for me with doctors when I couldn't do it myself.
- I wanted my trusted midwife, nurse, or support person to be contacted if possible. If I had a strong connection with someone, I needed them to be requested and to help advocate for me and explain things to others.

Safety and control preferences

- If it wasn't a medical emergency, I needed you to walk out the door and leave me alone with my trusted support person, or stay within eyesight if needed for safety.
- I needed you, as my trusted midwife, to stay with me.
- I needed to know what I could control and how, to reduce my uncertainty. I wanted some control – like self-administering medication or choosing who was in the room and where they stood – so I wouldn't feel completely out of control.
- I needed to be allowed to stay in the position that felt most comfortable to me – even if that meant curling up in a fetal position – instead of being told to move or be more upright.
- I appreciated when others did not make any changes (like changing the time that the doctor would visit).
- I asked for a reduction and restriction of visitors during my time on the ward.

Frequently asked questions

Are meltdowns and shutdowns during labour a sign that their patient is Autistic?

No. Meltdowns and shutdowns during labour are not definitive indicators of autism. Labour is an intense physical and emotional experience, and individuals – regardless of neurotype – can become overwhelmed due to pain, fear, sensory input, loss of control, or previous trauma.

Are meltdowns and disruptive behaviour the same thing?

No. Often, challenging behaviour and disruptive behaviour are used to incorrectly label what is actually a meltdown.

How do I get consent when someone goes in a shutdown mode or is having a meltdown?

A key challenge arises when someone enters shutdown and is no longer able to think or communicate clearly. In these moments, the absence of refusal should not be interpreted as consent. This can be tricky, especially in healthcare settings where timing and procedures are pressured. While we may not always be able to prevent shutdowns, we can take proactive steps to minimise the risk of proceeding without true consent. One helpful approach is to establish trust and consent pathways beforehand—for example, involving a trusted support person who understands the individual's communication needs and preferences. This can help ensure decisions are made in line with the person's wishes, even if they are not able to express them in the moment. The other strategy is to ask the individuals preferred communication method during a shutdown. For example, they may be able to respond to a written question or text/SMS request, despite spoken communication being too demanding.

Additional note:

Autistic pregnant people may also have support persons (spouses/partners, friends, family) who are Autistic/neurodivergent as well. They too can experience the overwhelm cascade, particularly if they are powerless to help their partner. Any discussions about decision-making/consent in preparation for possible meltdowns/shutdowns should keep this in mind and include these individuals in the discussion.

Resources

Falling into Shutdown: An Autistic Journey Beyond Overwhelm – Reframing Autism
reframingautism.org.au/falling-into-shutdown-an-autistic-journey-beyond-overwhelm/

All About Autistic Shutdowns/Meltodwns: A Guide for Allies – Reframing Autism
reframingautism.org.au/all-about-autistic-shutdown-guide-for-allies/

Young people explain meltdowns – Ambitious about Autism
youtube.com/watch?v=zseDl1V-BqU

References

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