Overlaps, similarities, and differences between borderline personality disorder and autistic spectrum disorder

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Swedish Personality Psychiatry Congress

6th May, 2026

AGENDA

- It's not always either/or: the BPD + ASC co-occurrence
- Similarities and differences – not just disability, abilities too?
- Diagnosis – whether, when, and how?
- Psychoeducation – how to adapt to two sets of needs?
- Treatments – is it a business of beg, borrow, or steal?
- Summarizing – what do we know and where next?

Overlap of autism spectrum disorder and borderline personality disorder

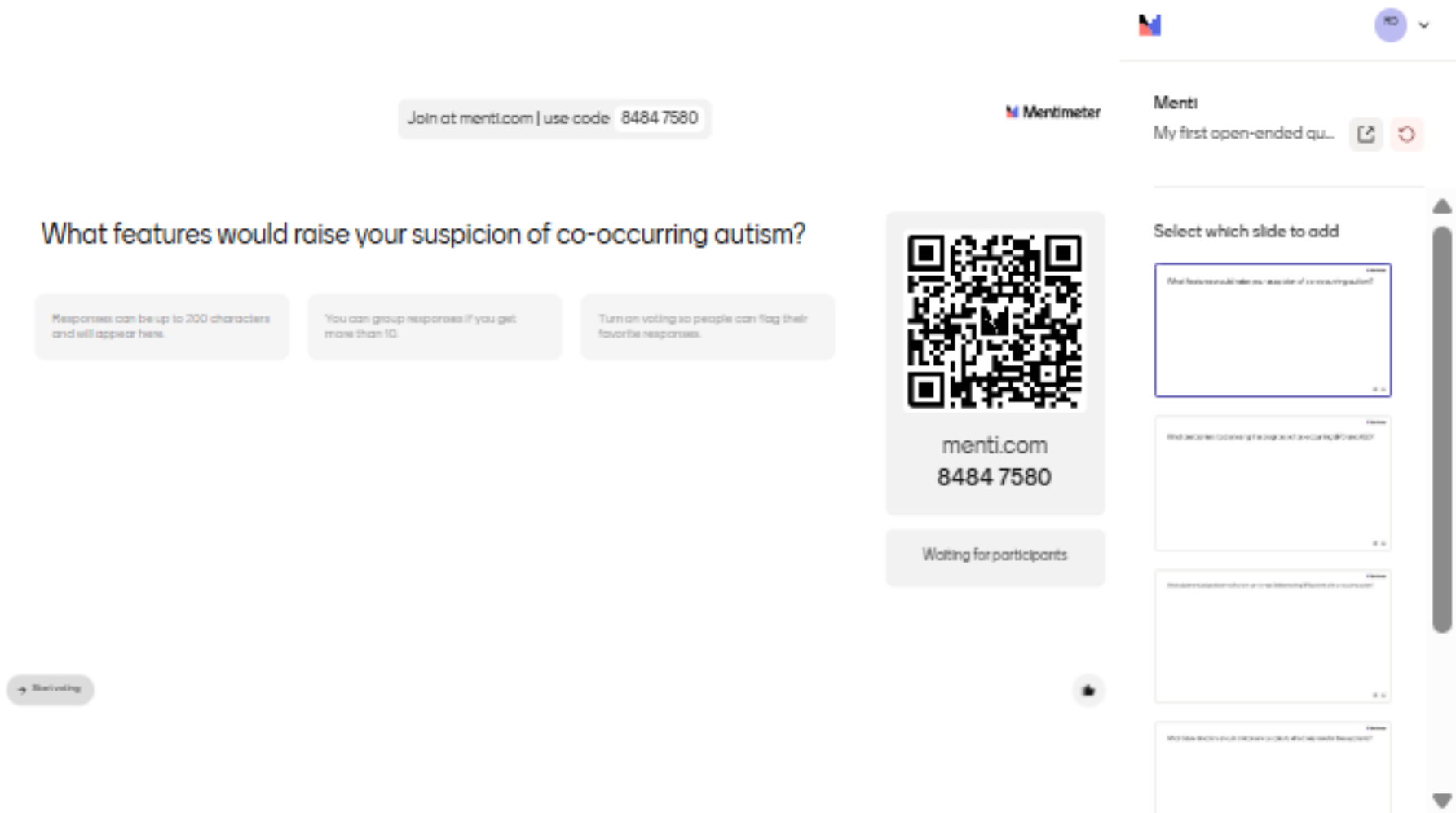
May et al (2021). Autism Res;14(12):2688-2710.

- Prevalence estimates vary according to study methodology
- BPD: cc 2%

- prevalence of autism in BPD: 3% [95% CI 1%-8%]
  - 5 studies with estimates ranging from 0% to 15%
  - mixture of methods to establish the diagnosis, including self-reported symptoms with the AQ

- Prevalence of BPD in autism in same study: 4% [95% CI 0%-9%]
  - 7 studies, with prevalences ranging between 0% and 12%

- Rough estimate of co-occurrence: 40k people in the UK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What features would raise your suspicion of co-occurring autism?
Responses can be up to 200 characters and will appear here.
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Similarities and differences between BPD and autism

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Dudas, R. B., & Cheney, L. (2025). Good psychiatric management of borderline personality disorder and co-occurring autism spectrum disorder. American Journal of Psychotherapy, 78(1), 35-45.

<table>
<tr><th></th><th>BPD</th><th>Autism</th></tr>
<tr><td rowspan="2">Affective instability, intense anger</td><td colspan="2">Focus on fairness, hypersensitivity to injustice</td></tr>
<tr><td>Interpersonal hypersensitivity</td><td>Sensory overload
Changes in person’s routine
“burnout” from social interaction</td></tr>
<tr><td rowspan="2">Difficulties in social relationships</td><td colspan="2">Starting from childhood
Strong focus on a few people
High moral standards</td></tr>
<tr><td>Intolerance of being alone
Strong emotional reactions → rejection
“Social chameleon”</td><td>Social withdrawal as coping
Difficulty fitting in with neurotypical social norms/neurotypical people having difficulty understanding autistic social behaviour → rejection/bullying

Camouflaging, masking</td></tr>
</table>

Typical autistic social behaviours that neurotypical (NT) people often misinterpret

Autistic social behaviour	Can be interpreted by NTs as …
“brutal” honesty (direct communication)	Rudeness
Averting gaze away to self-regulate	Inattentive/sneaky
Unmodulated voice	Lack of enthusiasm/boredom/anger
Showing interest by sharing information or small items related to their interest	Unrecognized as a gesture of friendship/feeling overwhelmed by information/feeling annoyed
Intense topic focus	Being self-centred
Social withdrawal during shutdown	Sulking

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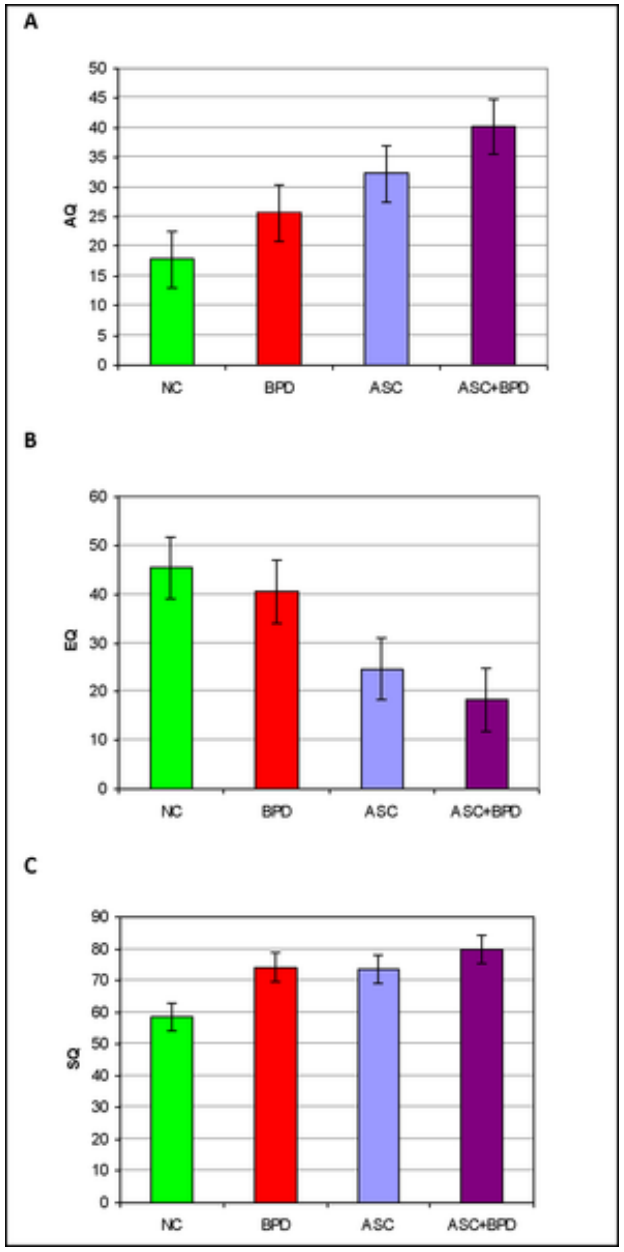
<tr><th></th><th>BPD</th><th>Autism</th></tr>
<tr><td rowspan="2">Identity disturbance</td><td colspan="2">Mental exhaustion from not being oneself in order to fit in with mainstream social expectations
Negative/unbalanced self-appraisals</td></tr>
<tr><td>Changeable interests</td><td>Enduring interests</td></tr>
<tr><td rowspan="2">Impulsivity</td><td colspan="2">Co-occurring ADHD common</td></tr>
<tr><td>Reckless spending/driving</td><td>Rigid pattern of thinking and behaving</td></tr>
<tr><td rowspan="2">Self-harm and suicidal behaviour</td><td colspan="2">Linked to unmet needs (loneliness, inadequate support)
Suicide can become a strong focus of interest
Associated with alexithymia</td></tr>
<tr><td>Interpersonal stressors</td><td>Camouflaging</td></tr>
</table>

The overlap between autistic spectrum conditions and borderline personality disorder



Dudas et al. (2017) The overlap between autistic spectrum conditions and borderline personality disorder. PLOS ONE 12(9): e0184447. https://doi.org/10.1371/journal.pone.0184447

The case Brittany

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Cheney et al. Co-Occurring Autism Spectrum and Borderline Personality Disorder: An Emerging Clinical Challenge Seeking Informed Interventions. Harvard Review of Psychiatry 31(2):p 83-91

21-year-old woman with BPD, referred to specialist PD service with

- high-lethality suicidal behaviours (ingesting toxic substances ad dangerous objects) and daily self-cutting
- a history of increasing restrictions within the family home for fear of the above

The case Brittany

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Cheney et al. Co-Occurring Autism Spectrum and Borderline Personality Disorder: An Emerging Clinical Challenge Seeking Informed Interventions. Harvard Review of Psychiatry 31(2):p 83-91

- Diagnosed with HFA at age 6 – narrow interests, preference for routine, sensory difficulties, high level of social interest but difficulty with reciprocity
- Also diagnosed with OCD and GAD
- Restricted eating and SH since teenage years when bullied by peers – started cutting to regulate emotions
- First admitted to psychiatry at age 15 – poor oral intake → general hospital
- Severe ED until age 17 when transferred to small school with good support → 2 years of stability
- Graduation → rapidly escalating suicidal attempts → referral to PD service

What tools do we have to help us with the diagnosis?

- DSM criteria for BPD and ASD – important caveats
- Screening and symptom rating tests:
    - ASC: AQ (Baron-Cohen 2001), RAADS-R (Ritvo et al 2011)
    - BPD: IPDE (Loranger et al 1994), PAI-BOR (Morey 1991)
- Coventry Grid for Adults (Cox et al 2019)
- Expert reviews and Delphi studies (Cheney et al 2023; Cumin et al 2021; Gordon et al 2020)

The Coventry Grid for adults

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Cox et al. The Coventry Grid for adults: a tool to guide clinicians in differentiating complex trauma and autism. Good Autism Practice; May2019, Vol. 20 Issue 1, p76-87, 12p

Inflexible thinking and behaviour
Intense and restricted interests
Social interaction/communication difficulties
Mentalizing/ToM difficulties
Emotional dysregulation
Executive dysfunction

Positive and differential diagnosis of autism in verbal women of typical intelligence

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Cumin et al. Autism. 2022 Jul;26(5):1153-1164.

20 experienced psychologists, psychiatrists, and SLT from 7 countries interviewed

Aims:

- Study the decision-making process of expert clinicians
- Examine the impact of gender-based interpretation biases
- Guidance for clinicians assessing women for autism

37 clinical consensus statements

- females can appear more neurotypical (NB., less empathy towards self than others)
- standard tools not equipped
- social desirability of autism diagnosis
- self-diagnosis common
- spontaneous interaction versus self-report questionnaires, lived experience vs pt's research
- explain diagnosis may not be made/validate experience
- coproduce final report
- BPD common differential (different attachment)
- ability to offer alternative avenues to those not diagnosed with autism to avoid harm
- further training and exposure to BPD and PTSD for clinicians

Differential diagnosis of autism, attachment disorders, complex post-traumatic stress disorder and emotionally unstable personality disorder: a Delfi study

-

Sarr et al. Br J Psychol. 2025 Feb;116(1):1-33

Co-produced, 3-round Delphi with 106 international professionals with expertise in assessing at least one of these conditions

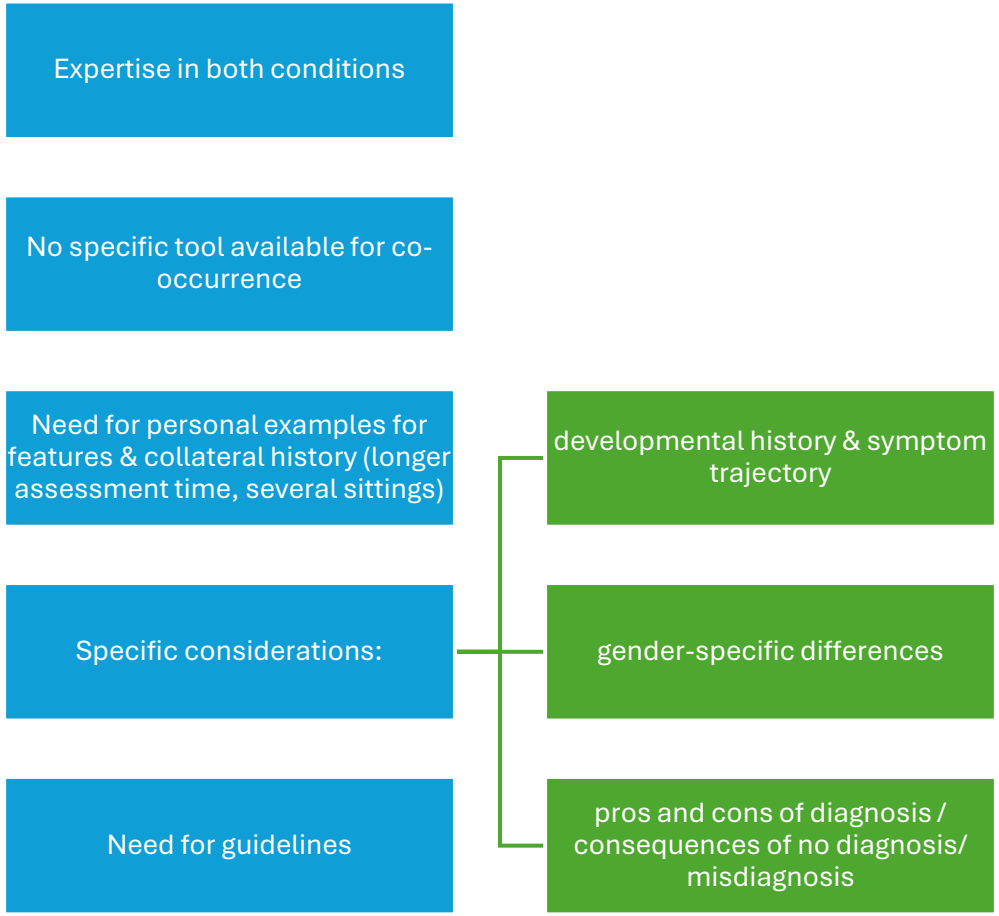
Results:

- 275 statements
- Overlapping and differentiating features (co-occurring ASC+EUPD: did not reach consensus)
- Assessment methods for differential diagnosis
- Difficulties encountered during differential diagnosis
- Suggestions for improvement for differentiating ASC and EUPD:
    - access to specialist supervision and consultation
    - integration of neuro-developmental and mental health services
    - not relying on one tool or measure
    - research on co-occurring autism and EUPD

Remaining gaps in knowledge/lack of consensus:

- Hierarchy and/or sequential order of identified pointers in the diagnostic process
- Not on treatment

In summary…


Expertise in both conditions
No specific tool available for co-occurrence
Need for personal examples for features & collateral history (longer assessment time, several sittings)
Specific considerations:
Need for guidelines
developmental history & symptom trajectory
gender-specific differences
pros and cons of diagnosis / consequences of no diagnosis/ misdiagnosis

The case Brittany

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Cognitive assessment

- Relatively strong language function
- Striking difficulty with executive function: planning, organization, problem solving
- Very poor social inference of more nuanced emotions whilst intact understanding of straightforward interactions

AQ: 26/50 (cut-off: >32)

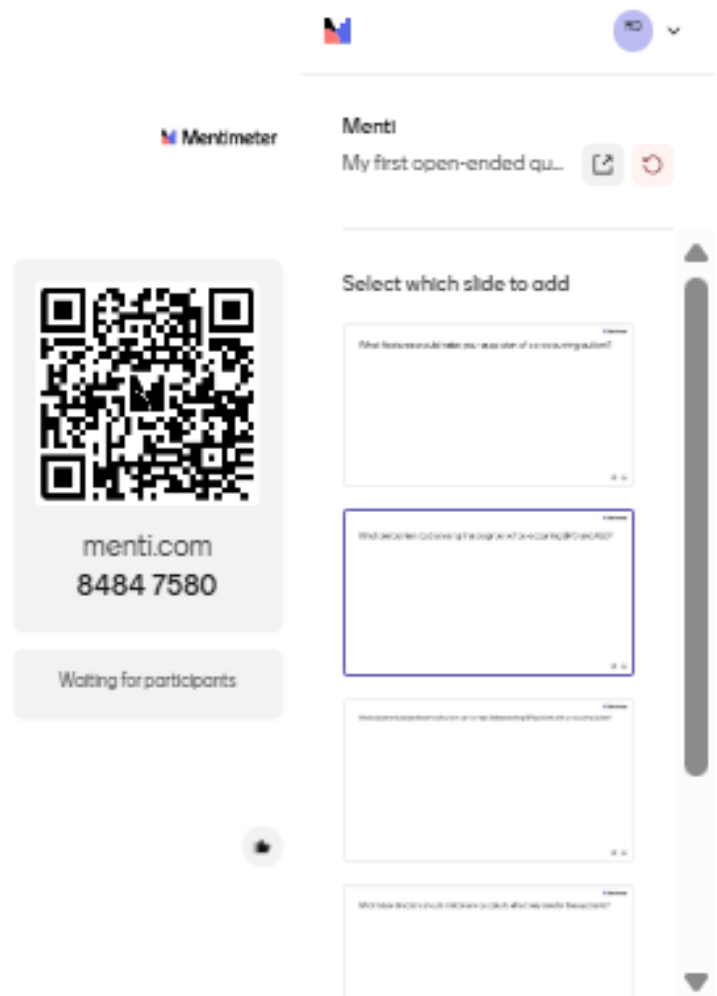
EQ: 37/80 (cut-off: <30)

NB, both self-report and influenced by level of insight

McLean Screening Instrument for BPD : 10/10

→ BPD diagnosis confirmed, as better explained high-risk SH, suicidal behaviour, impulsivity, severe emotion dysregulation, intense anger, unstable relationships, persistently unstable self-image.

What are barriers to disclosing the diagnosis of co-occurring BPD and ASD?



How to disclose the diagnosis

- Establish rapport/epistemic trust whilst considering autistic needs and preferences
- Relate person's experience to the diagnostic criteria and examine the person's reactions
- Co-producing the diagnosis is helpful (Cumin 2022; Bolton et al 2014)
- Post-diagnostic counselling → psychoeducation (BPD: Morris et al 2014; ASC: Beresford et al 2023)
- Common challenges: patient refusing either/both diagnoses; not fully meeting criteria; stigma

Psychoeducation

Crucial for managing this co-occurence, focusing on aetiology, symptoms, and treatment options

Tailored, face-to-face, multi-session programs recommended for individuals and their families

Heritability + life experiences + adaptations to accommodate autistic needs → potential improvement

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What adjustments/adaptations/modifications can be helpful when treating BPD patients with co-occurring autism?

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Treatment principles

- Social understanding challenged → avoid neurotypical group setting
- High sensory sensitivity → environmental adaptations (Autistic SPACE framework)
- Difficulty with abstract concepts → specific modifications

- Map personal neurocognitive, social cognitive, and sensory profile
- Adapted goal setting to achieve & maintain functional autonomy

Setting goals

Adjust goals:

- Informed workplace can accommodate differences and maximize strengths
- Explore a different range of occupations and employment activities that fit with the person’s interests

Safety management

- Heightened risk of self-harm and suicide
- Collaborative chain analysis to identify the triggers – exhaustion from camouflaging, unmet support needs
- Personalized crisis plan –
  - reduce sensory overload
  - self-soothing techniques
  - low-dose, short-term medication treatment
  - clear communication
  - avoid multiple clinicians
  - minimize hospitalization
- The best way we can stop suicides is by making lives worth (Moseley 2026)

Multimodal treatments

GPM encourages integrating additional therapeutic approaches

Treatment must be personalized to accommodate the heterogeneity of autism

Medications for comorbid conditions – NB, sensitivities and overdose risks

DBT skills training

cognitive enhancement therapy (Eack 2018)

family involvement

MBT-ASD (Kramer 2021)

adapted DBT (Bemmouna 2023)

adapted ACT (Pahnke 2019, 2022)

BPD treatments adapted for autism

- Co-occurrence more challenging to treat (mainstream treatments designed for “pure” BPD)
- New potential treatments emerging with promise for comorbidity:
    - MBT for ASD (Krämer et al 2021)
    - DBT for ASD (Bemmouna et al 2021)

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TREATMENT

Initially based on BPD treatment principles based on autonomy:

- DBT – engaged well but felt that skills did not help her in crisis (struggled with abstract concepts)

Later changed to neurodiversity-based primarily, with BPD is secondary:

- Focus on disability services
- Psychotherapy to maximize reflective capacity but with round-the-clock support to apply the interventions
- Now transitioning to 24-hour supported living

The usefulness of values in BPD

- Values are linked to emotions
- Values transcend individual situations

- Acting in line with one's values can lead to clinical improvement in BPD (Morton 2012)
- Adding value component to DBT may enhance motivation and treatment efficacy in BPD (Cameron 2014)

BPD treatment research including values

ACT+TAU > TAU for symptom improvement, emotion regulation, mindfulness, and reducing fear of emotions (Morton 2012)

ACT = DBT = ACT+DBT+FAP for reducing symptom severity and experiential avoidance, improving mindfulness skills (Reyes-Ortega 2020)

Wise Choices

Wise Moments

What do we know about the values of autistic people?

- Autistic people can have access to their existential values but this is affected by masking which can complicate their access to their sense of self
- Their core values can be unconventional
- They often define themselves by what they love (their values)
- Intense focus on fairness and logic (they prioritize truth over social comfort)
- Existential distress due to loneliness
- Experience is structured by interests more than by social connections
- The best way we can stop suicides is by making lives worth (Moseley 2026)

ACT studies for autism

Pahnke et al 2014 pilot study

28 students (aged 13-21) with HFA

6-week ACT-based skills training (2 weekly 40-min group sessions and daily mindfulness practices) or waitlist control.

Levels of stress, hyperactivity and emotional distress reduced and prosocial behaviour increased

Changes stable/further improved at the 2-months

Pahnke et al 2019

10 adults with ASD in OPC

12 weekly 150 min' group sessions with modified ACT (NeuroACT)

Improvements in perceived stress (including at 3-month follow-up), QoL, depressive symptoms, social impairment, psychological inflexibility, and cognitive fusion

Pahnke et al 2022

RCT, N=39, 14-week NeuroACT vs TAU

Perceived stress, QoL, psychological inflexibility, cognitive fusion, avoidance, and mannerism improved (d = 0.7–0.9)

Clinically significant changes

Summarizing thoughts

EPIDEMIOLOGY

- The co-occurrence of BPD and autism presents significant clinical complexity in services
- Not all people with autism have ASD

Summarizing thoughts

DIAGNOSIS

- Need for low-stimulation, sensory-friendly environments for safety
- Thorough assessment by professionals familiar with both conditions
- Be aware of different presentation of autism in females and risk of diagnostic overshadowing

Summarizing thoughts

TREATMENT

- Create environments with reduced sensory input
- Use direct communication
- Be aware of increased risks of suicidality, depression, and trauma

- Treatment must address both emotional dysregulation (BPD) and sensory/cognitive needs (ASD) simultaneously
- Need for highly personalised treatment plans

- GPM provides a foundational framework while emphasizing recovery, occupational functioning, and consistent therapeutic relationships
- Modalities used in BPD treatment (DBT, MBT, ACT) may work but need to be adapted – working with values is important

- Reducing loneliness and inclusion in society = key to recovery


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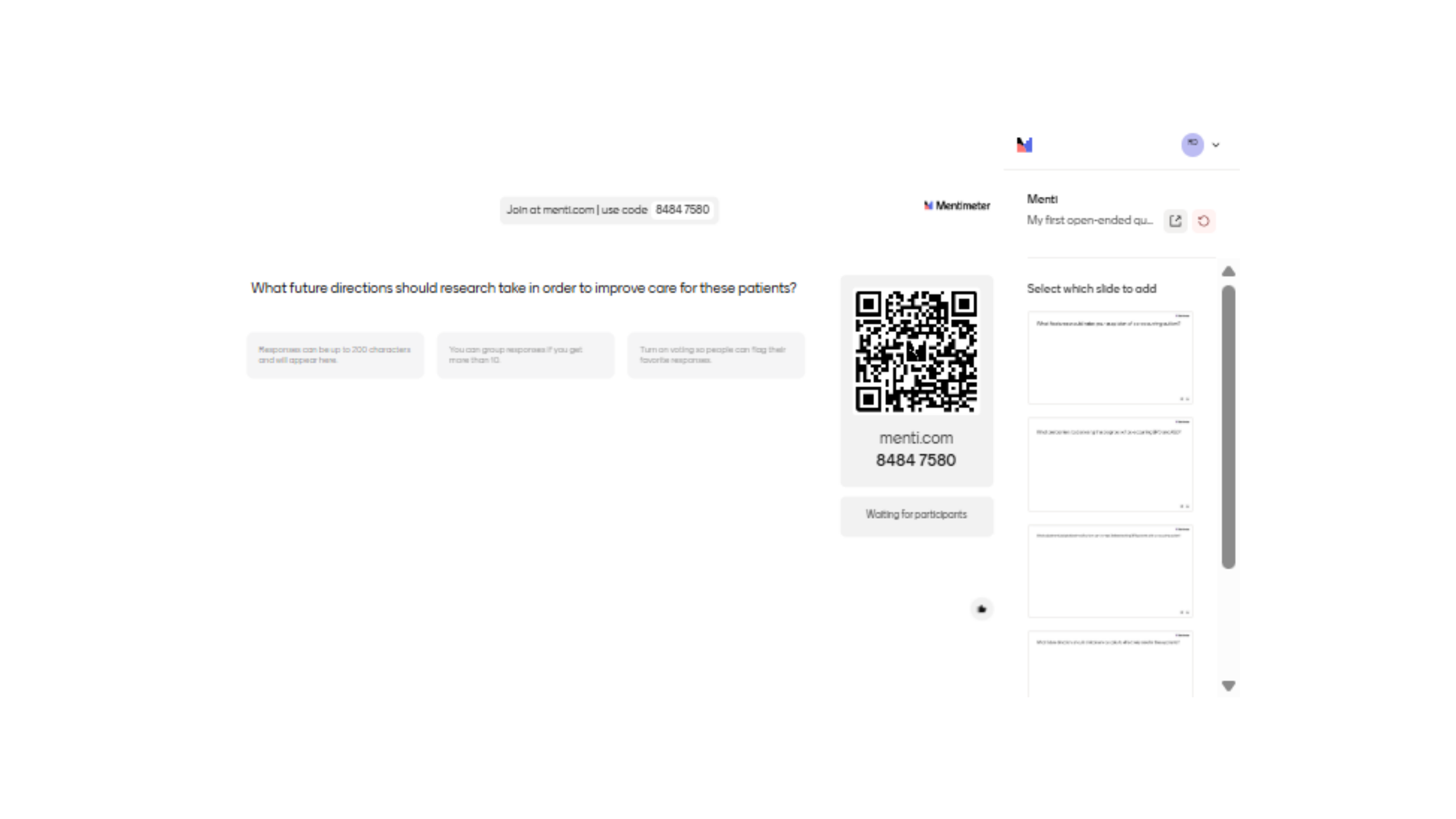
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My first open-ended qu...
What future directions should research take in order to improve care for these patients?
Responses can be up to 200 characters and will appear here.
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