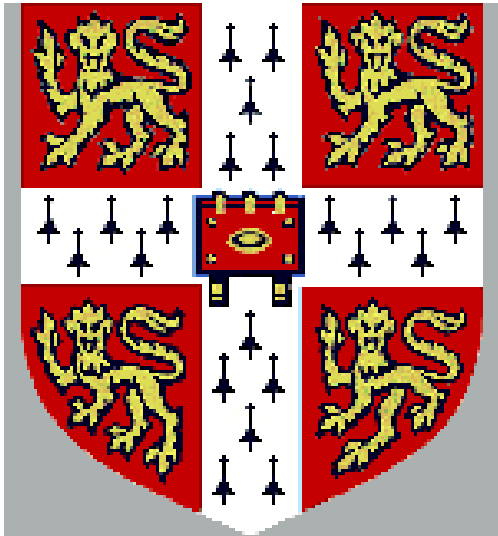


# Overlaps, similarities, and differences between borderline personality disorder and autistic spectrum disorder

**NHS**

Cambridgeshire and  
Peterborough  
NHS Foundation Trust



**Dr Robert B. Dudas, MD, PhD (Cantab), FRCPsych, PGCert Med Ed**

Consultant Psychiatrist, OPMHS, Cambridgeshire and Peterborough NHS Foundation Trust

Affiliated Assistant Professor, Department of Psychiatry, University of Cambridge


Training Programme Director for Psychiatry, NHS England, East of England


Academic Secretary, Eastern Division, Royal College of Psychiatrists, UK

**Swedish Personality Psychiatry Congress**

**6<sup>th</sup> 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.

You can group responses if you get more than 10.

Turn on voting so people can flag their favorite responses.

Start voting

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Select which slide to add

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# Similarities and differences between BPD and autism

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.

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

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

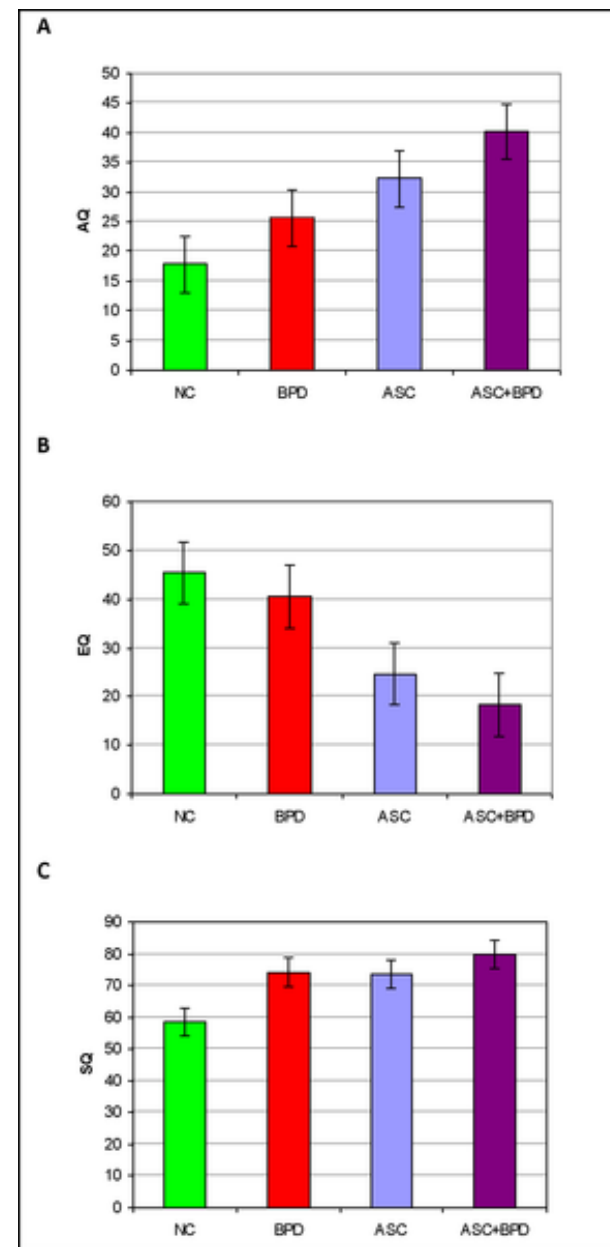
<b>Autistic social behaviour</b>	<b>Can be interpreted by NTs as ...</b>
“brutal” honesty (direct communication)	Rudeness
Averting gaze away to self-regulate	Inattentive/sneaky
Unmodulated voice	Lack of enthusiasm/boredom/anger
Showing interest by sharing information or small items related to their interest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

# Similarities and differences between BPD and autism

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.

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

# 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

-

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 and dangerous objects) and daily self-cutting
  - a history of increasing restrictions within the family home for fear of the above
-

## The case Brittany


-


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

Cox et al. The Coventry Grid for adults: a tool to guide clinicians in differentiating complex trauma and autism. Good Autism Practice; May 2019, Vol. 20 Issue 1, p76-87, 12p

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Inflexible thinking and behaviour

---

Intense and restricted interests

---

Social interaction/communication difficulties

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Mentalizing/ToM difficulties

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Emotional dysregulation

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Executive dysfunction

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

-  
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 Delphi 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

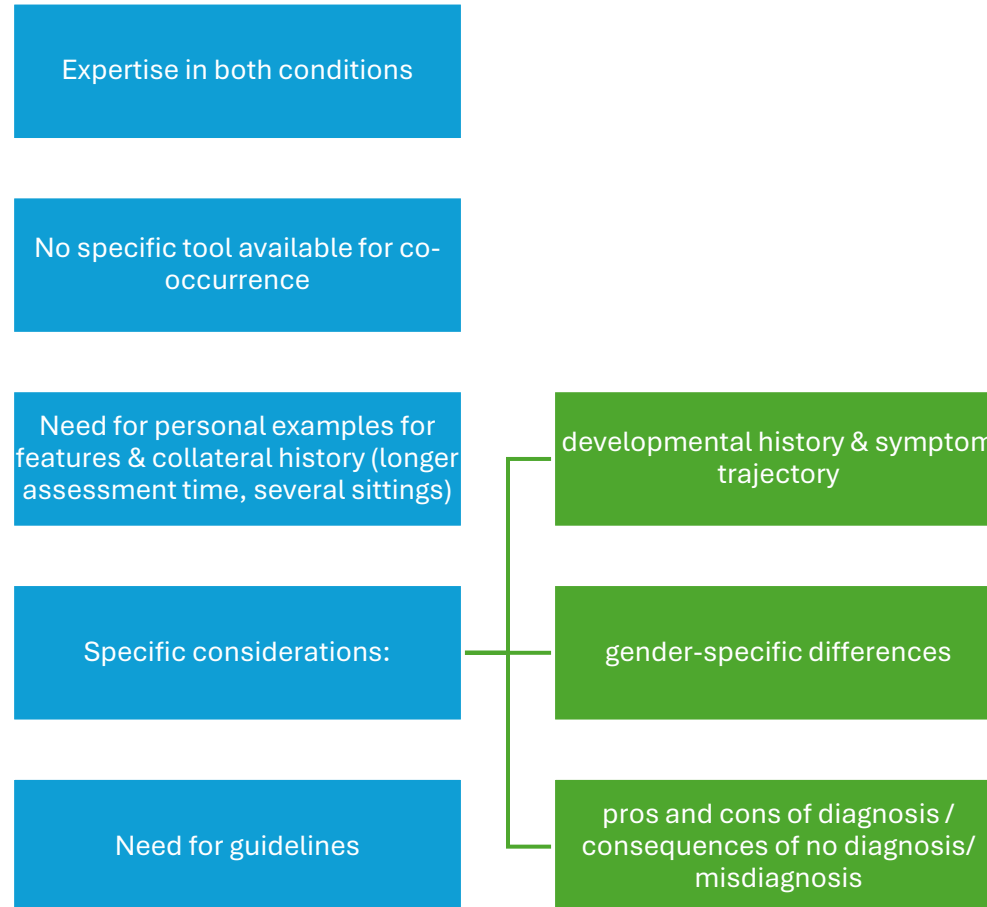
## **Results:**

- 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...



## The case Brittany

-

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

### 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?

→ Start voting



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Select which slide to add

What factors could make the disclosure of co-occurring BPD and ASD?

What barriers could make the disclosure of co-occurring BPD and ASD?

What barriers could make the disclosure of co-occurring BPD and ASD?

What barriers could make the disclosure of co-occurring BPD and ASD?



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# 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-occurrence, 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?

Responses can be up to 200 characters and will appear here.

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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)

## The case Brittany

-

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

### 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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Select which slide to add

What features add the most value of connecting online?

What features add the most value of connecting offline?

What features add the most value of connecting in person?

What features add the most value of connecting in person?

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What future directions should research take in order to improve care for these patients?

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Thank you  
for your  
attention!