Why you should read this article:

- To enhance your knowledge of the similarities and differences between borderline personality disorder (BPD) and autism spectrum disorder (ASD)
- To assist you in developing effective treatment and management plans for people with BPD and/or ASD
- To understand the complexities involved in diagnosing and managing people with co-morbid BPD and ASD

Differentiating between borderline personality disorder and autism spectrum disorder

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Abstract

One of the main issues that people with borderline personality disorder (BPD) and/or autism spectrum disorder (ASD) experience is that they find emotional and relational interactions challenging.

This article reviews the available literature on the similarities and differences between BPD and ASD, and aims to raise awareness of the complexity of co-morbid presentations. This is important because, if a person's diagnosis is inaccurate or incomplete, their treatment may be ineffective or inappropriate. The authors provide practical guidelines to assist front-line mental health practitioners in diagnosing BPD and/or ASD, thereby enabling them to develop appropriate and effective management plans. These guidelines were drawn from the available literature and the authors' experience in clinical practice. When BPD and ASD co-occur, a formulation approach should be used to provide person-centred care, rather than an assessment approach that simply defines the issues a person is experiencing.

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Keywords

autism, borderline personality disorder, clinical guidelines, diagnosis, learning disability, mental health, nursing care, personality disorders, professional

Background

Borderline personality disorder (BPD), also known as emotionally unstable personality disorder, is broadly defined as a pervasive pattern of instability in interpersonal relationships, self-image and emotions, alongside marked impulsivity beginning in early adulthood and present in a variety of contexts (American Psychiatric Association (APA) 2013). It is characterised by impairment in interpersonal functioning, for example low empathy or issues with trust and intimacy, as well as personality traits, such as disinhibition and antagonism, as well as impulsivity. The lifetime prevalence of BPD is around 6%, and the condition is equally prevalent among men and women (Grant et al 2008).

Autism spectrum disorder (ASD) is characterised by the presence of social and communication difficulties, alongside unusually strong, narrow interests and/or unusually repetitive and stereotyped behaviour (APA 2013). Autistic traits may include systemising, a process of using systems and rules to predict behaviour rather than empathising,, and deficits in mentalisation, the ability to understand the mental state of oneself or others. ASD is more often diagnosed in men than in women, and the prevalence is estimated to be 1% (Baron-Cohen et al 2009).

The aetiology for BPD and ASD is not fully understood, but is believed to be a combination of genetic and environmental factors. There is a common understanding that ASD is a developmental neurological disorder, while BPD is more associated with adverse environmental factors, such as emotional deprivation, abuse and trauma in childhood (Dudas et al 2017). However, it is possible that some people may experience both conditions.

Accurate diagnosis of BPD and/or ASD is essential if healthcare practitioners are to identify optimal treatment pathways for each individual. Diagnosis can be complex because there are several similarities in presentation across diagnostic criteria, co-morbidity and differential diagnoses (Dudas et al 2017). For example, one of the main similarities between BPD and ASD is that in both conditions people can experience significant challenges in understanding and responding to emotions in themselves and in relation to others. This can have a negative effect on their ability to function and feel content interpersonally (Dudas et al 2017).

Assessing the differences between BPD and ASD is important because the treatment and management approaches for each condition are different. For example, in people with ASD, self-harm is strongly associated with sensory overload, while in people with BPD it tends to occur in the context of interpersonal conflict and emotional dysregulation (Dudas et al 2017). Therefore, in ASD it may be appropriate to minimise self-harm by reducing activities causing sensory overload, while in BPD there is evidence that psychological interventions that reduce emotional dysregulation and impulsivity are effective (Dudas et al 2017). It is important to identify people with co-morbid BPD and ASD since the co-occurrence of these conditions can mean it is more complex to determine effective treatment pathways for them. This is because the traits of these conditions may compound each other and, if not identified, may render treatment ineffective.

The authors undertook a literature review to determine the similarities and differences between BPD and ASD, and to identify any challenges in diagnosis and treatment where they co-occur.

Literature review

A literature search was conducted in January 2019 using the databases PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE. The following search terms were used: 'borderline personality disorder', 'BPD', 'emotionally unstable personality disorder', 'EUPD', 'ASD', 'autistic spectrum disorder', 'autism', 'diag*', 'differential', 'identification', 'association', 'crossover', 'correlation', 'link' and 'relation' (Linsey 2019). Articles were included if they were published between 2008 and 2019, and were in English. The aim of the literature review was to identify any articles that were concerned with both BPD and ASD. No specific research question or framework was used. Six published studies were found and included in the literature review (Rydén et al 2008, Strunz et al 2015, Dudas et al 2017, López-Pérez et al 2017, Chabrol and Raynal 2018, Dell'Osso et al 2018).

Chabrol and Raynal (2018) found that high BPD and autistic traits co-occurred in 17% of their sample of young adults, while in Dell'Osso et al's (2018) study people with BPD reported higher autistic traits than people without BPD. Dudas et al (2017) undertook a control study with a relatively large sample that included those diagnosed with BPD, ASD and co-morbid diagnoses, finding that people with BPD had elevated autistic traits and a strong drive to systemise, suggesting an overlap between BPD and ASD.

Dudas et al (2017) reported that people with BPD and those with ASD often experience significant issues in understanding and responding to emotions and interpersonal functioning. Therefore, differentiating core BPD and ASD traits and establishing any co-occurrence of these conditions can be challenging for service users and healthcare practitioners. Strunz et al (2015) asserted that differentiating ASD without accompanying intellectual impairment from personality disorders can be challenging, and suggested that identifying specific personality traits and personality pathology specific to ASD might assist in diagnosis. They found that, compared with individuals with BPD, people with ASD without intellectual impairment scored lower on extraversion and openness to experience, and higher on feelings of inhibition and compulsivity.

Interpersonal emotional regulation has a significant role in how people relate to one another and is important in initiating and maintaining social relationships. It is well known that people with BPD and those with ASD exhibit differences and difficulties in social interactions. One study, by López-Pérez et al (2017), investigated what interpersonal emotion regulation strategies people with BPD or Asperger's syndrome, a form of ASD, employed. They found that

Key points

- One of the main similarities between borderline personality disorder (BPD) and autism spectrum disorder (ASD) is the significant challenges people face in understanding and responding to emotions in themselves and in relation to others
- The literature suggests that people with BPD generally tend to be less introverted and socially inhibited, less compulsive and more open to new experiences than people with ASD
- People with BPD and those with ASD exhibit differences and difficulties in social interactions
- Treatment and management plans should be developed and agreed with service users, to support them to make informed decisions about their treatment and improve their engagement

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those with Asperger's syndrome tended to use more maladaptive strategies, such as expressive suppression, and less adaptative strategies, such as attention deployment or cognitive change, than those with BPD and the control group. The authors emphasised the need to tailor emotional regulation interventions to each person (López-Pérez et al 2017).

It is important for healthcare practitioners to recognise any potential co-occurrence of BPD and ASD because this appears to correlate with increased risk to self. Dell'Osso et al (2018) identified that autistic traits affected some clinical features of BPD, such as suicidality and lifetime exposure to physical and/or sexual abuse. In Chabrol and Raynal's (2018) study, young adults with co-occurring BPD and ASD traits had higher levels of suicidal ideation than the BPD traits group, despite similar levels of depressive symptoms. Rydén et al (2008) found that, in their small sample of people with BPD, 15% had co-occurring autistic traits, and that this group had disproportionately more suicide attempts. This finding indicates that people with co-morbid BPD and ASD are at increased risk of suicide.

Limited evidence could be found of any guidelines on differentiating BPD and ASD, aside from the Coventry Grid (Moran 2010). This tool was developed to assess the similarities and differences between attachment disorder, which is linked with the diagnosis of BPD in adults (Dozier et al 2008), and ASD in children with mental health issues.

Discussion

Most of the studies included in the literature review identified co-morbid BPD and ASD as a distinct group in their samples (Rydén et al 2008, Dudas et al 2017, López-Pérez et al 2017, Chabrol and Raynal 2018, Dell'Osso et al 2018). Three of these studies found higher levels of suicidality in this group (Rydén et al 2008, Chabrol and Raynal 2018, Dell'Osso et al 2018), and one found that co-morbidity correlated with greater exposure to physical and/or sexual abuse (Dell'Osso et al 2018).

Most of the included articles emphasised the importance of using individualised approaches to developing treatment and management plans for people with BPD and/or ASD. Where possible, these plans should be developed and agreed with service users, to support them to make informed decisions about their treatment and improve their engagement.

It was identified from the literature that differentiating BPD from ASD is more challenging in people with ASD without accompanying intellectual impairment. It is likely that this is also the case when BPD is co-morbid with an intellectual impairment, although no studies were found to support this.

The literature suggests that people with ASD generally tend to be more introverted and socially inhibited, more compulsive and less open to new experiences than people with BPD. People with ASD also tend to suppress emotional expression in social circumstances. People with BPD appear to share autistic traits such as systemising and mentalising (Dudas et al 2017), although caution in making generalisations is suggested. For example, a person with ASD may have difficulty interpreting social cues and thereby become isolated, which differs from a person who is naturally introverted and has no difficulty interpreting social cues, but chooses not to be socially involved. This example emphasises the need for an individualised approach in the diagnosis and management of BPD and ASD, particularly where the conditions may be co-morbid.

Development of guidelines to support diagnosis

Table 1 details guidelines that the authors developed to support the diagnosis of BPD and/or ASD. The authors developed these guidelines after identifying several cases of misdiagnosis that contributed to problematic and ineffective treatment and management plans for people with BPD and ASD.
A formulation approach (Yeandle et al 2015), which involves developing an understanding of the origin of a person's issues, for example early experiences and relationships that might have led to their current functioning, was used to develop a classification system to support accurate diagnosis and therefore lead to appropriate and effective management plans. The differentiating descriptions in the guidelines are not designed to be used as a diagnostic tool, but the discussion points can aid collaborative identification of diagnostic features, which can then enable service users to make informed decisions about their treatment.

The guidelines have been implemented in Somerset Partnership NHS Foundation Trust mental health services for approximately one year. They have been adapted for use in local healthcare practitioner training sessions, and were initially trialled as part of staff training, supervision and consultation. Feedback provided from training evaluations and informally have indicated that the guidelines are useful and have been welcomed

Table 1. Guidelines to support the diagnosis of borderline personality disorder and/or autism spectrum disorder

Behaviour or presentation	Borderline personality disorder (BPD)	Autism spectrum disorder (ASD)	Discussion points
Psychological improvement	» Most people with BPD can be expected to make significant psychological improvements or recover over time	» There is less expectation of changing deficits in the general reflective ability of people with ASD » Some behavioural changes can be achieved	» Are there signs that the person can make changes in their understanding and reflective ability? » Does the treatment largely need to be focused on goal-oriented behavioural strategies?
Mentalisation ability	» This reflective function can fluctuate dramatically according to the person's level of emotional distress, but when calm they can be expected to be able to mentalise effectively	» Emotional dysregulation may cause some fluctuation, but overall mentalisation deficit will remain relatively constant	» Does the person's ability to reflect on their own and others' mental states fluctuate markedly in response to emotional distress? » When the person's emotional state is calm, are they relatively able to reflect on their own and others' inner states?
Emotional sharing	» There is a tendency towards intense emotional involvement that can include excessive disclosure of feelings and personal history	» There is reduced sharing of emotions	» If the person feels safe enough with another person, are they likely to want to share details about their emotional life intensely?
Empathy	» Empathy is often heightened, albeit negatively biased. For example, a person may be attuned to rejection based on a fear of abandonment	» The person has reduced empathy	» Does the person recognise others' feelings quickly and easily, but tend to have a negative bias about how they interpret them? » Can the person give effective emotional advice to others when not distressed themselves?
Visual cues	» People with BPD tend to perceive subtle signs of emotion	» People with ASD are likely to need strong visual demonstrations of an emotional state in another person to recognise and identify the emotion	» Does the person recognise subtle signs of emotion? » Does the person need emotions to be strongly demonstrative to recognise them?
Repetitive behaviours	» Repetitive behaviours such as ritualistic self-harm may be evident. These behaviours are likely to serve to regulate emotion and be absent at times of emotional stability	» Highly repetitive behaviours are a diagnostic feature without there necessarily being an emotional component	» Do the person's rituals or repetitive behaviours serve an emotion regulation function? » Are the person's rituals largely absent when their emotions are well regulated?
Childhood trauma and neglect	» These are often, although not always, relevant » They can affect emotional recognition and processing (alexithymia)	» People with ASD may have experienced this, but it is not considered a significant factor in causation	» Did the person's personality difficulties stem from childhood neglect or abuse? » Were the person's difficulties evident before or in the absence of trauma? » Were the person's family dynamics inhospitable to developing emotional recognition and naming skills?
Invalidation in relation to aetiology	» Invalidation is an important factor in the aetiology of their difficulties » Invalidation in the family is more likely and more detrimental in emotionally vulnerable people, such as those with BPD	» People with ASD may have experienced this, but it is not considered a significant factor in causation	» Does repeated invalidation by caregivers appear in the person's description of their developmental history? » Does the person demonstrate deep sensitivity to signs of invalidation by others?
Emotional validation	» Appropriate emotional validation markedly reduces emotional hyperarousal » Emotional validation is a primary way of developing rapport	» Emotional validation has less significant effects than in people with BPD, and may not be relevant	» Does accurate emotional validation significantly reduce the person's emotional arousal?
Physical proximity	» This may be an issue at times and be psychologically based	» This may be an issue at times, and may be pragmatic, for example if other people are 'in the way'	» Does the person experience post-traumatic symptoms from physical proximity? » Does the person have intense anxiety about judgements and criticisms of others, which may cause hyperarousal and distancing from others?
Social engagement	» Deficits in social engagement may be a transient presentation related to dissociation	» Deficits in normal social engagement are a pervasive feature	» Does the person experience shifts into dissociative states when they are distressed? » Do the person's social skills vary considerably depending on their level of anxiety?
Self-harm	» This tends to occur in the context of emotional dysregulation, often connected to interpersonal conflict	» This is associated with sensory overload and may be their attempt to communicate about an issue » It is not exclusively for emotional or interpersonal reasons	» Does the person's treatment need to be aimed at reducing activities that cause sensory overload (adaptation to the environment) or at reducing emotional overload and increasing reflective ability? » What are the functions of self-harm for the person?
Attachment and rejection	» A pattern of attachment and rejection is common in relationships	» People with ASD tend to have a more constant level of engagement than those with BPD » They may actively engage with others then withdraw from them, but for practical rather than emotional reasons	» Does the person have intense periods of emotional engagement with others followed by periods of rejecting or withdrawing from them, as opposed to a relatively constant level of engagement? » Is the person's pattern in relationships largely because of emotional reasons or for reasons that are functional and pragmatic?

by front-line staff. They have also been incorporated into the trust's good practice guide. The guidelines were originally based on similarities in the presentation of people with BPD and people with ASD, and the authors had not considered the co-morbidity that was identified in the literature. On reflection, the guidelines are also beneficial where this overlap occurs, because increased risk is an important consideration in planning and delivering the care of these individuals.

Conclusion

Mental health diagnosis and classification systems can assist in communication, and identify treatment pathways and research. However, they may also be associated with potential limitations if the person's diagnosis is linked inappropriately to a single treatment or management plan. This can result in care that aims to treat set diagnoses rather than the individual being ineffective. Clearly identifying a person's issues can define treatment approaches and therefore set realistic expectations and goals based on individual needs. This is particularly important where BPD and ASD co-occur, which may require an individualised approach to treatment and management. A formulation approach that emphasises the importance of understanding the reasons for a person's issues can be more beneficial than an assessment approach, which simply defines the issues a person is experiencing.

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