Reflective questions for professionals to consider in the differentiation of Autistic Spectrum Disorder and Borderline Personality Disorder

The points and questions below are proposed as useful for assessment differentiation of these two conditions. The format is that there is a discussion point for clarification followed by questions to enable exploration. They are not definitive and the authors welcome comments and suggestions.

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The majority of BPD clients can be expected to make significant psychological improvements or recover over time, in ASD clients there is less expectation of changing core reflective function deficits although some behavioural change can be achieved.

Are there signs the client can make changes in understanding and reflective ability?

Does the treatment largely need to be focussed on goal oriented behavioural strategies?

BPD clients’ mentalisation (reflective function) ability can fluctuate dramatically according to their level of emotional distress but when calm they can be expected to be able to mentalise effectively. Emotional dysregulation in ASD clients may cause some fluctuation however the overall mentalisation deficit will remain relatively constant.

Does the client’s ability to reflect on their own and other’s mental states fluctuate markedly in response to emotional distress?

When the client’s emotional state is calm are they relatively able to reflect on their own and other’s inner states?

ASD clients have reduced sharing of emotions, BPD clients tend towards intense emotional involvement that can include excessive disclosure of feelings and personal history.

If the client feels safe enough with another person are they likely to want to share more intensely about their emotional life?

Empathy can be reduced in ASD clients but is often heightened albeit negatively biased in BPD clients.
Does the client pick up on feelings of others quickly and easily but tend to have a negative bias about how they interpret them?

Can the client give good emotional advice to others when not distressed themselves?

ASD clients are likely to need a more visual demonstration of an emotional state in another person in order to recognise and possibly identify the emotion. BPD clients tend to perceive subtle signs of emotion.

Does the client pick up subtle signs of emotion?

Does the client need emotions to be strongly demonstrative in order to recognise them?

Highly repetitive behaviours are a diagnostic feature in ASD clients without there necessarily being an emotional component. If repetitive behaviours are evident in BPD (e.g. self harm may be ritualistic and repetitive) these are likely to serve an emotion regulation function and be relatively absent at times of emotional stability.

Do the client’s ‘rituals’ or repetitive behaviours serve an emotion regulation function and are they largely absent when the client is well regulated?

The role of childhood trauma and neglect is not a significant factor in ASD clients but often (not always) relevant in BPD clients.

Did the client’s personality problems stem from childhood neglect or abuse?

Were the client’s problems evident prior to or in the absence of trauma?

Invalidation is seen as an important factor in the aetiology of BPD clients’ problems but not specific to ASD clients. Invalidation in the family is more likely to happen and to be more detrimental with an emotionally vulnerable individual.

Does repeated invalidation by care givers appear in the client’s description of their developmental history?

Does the client demonstrate deep sensitivity to signs of invalidation by others?

Appropriate validation markedly reduces emotional hyper-arousal in BPD clients. This may be less significant an effect in ASD clients. Emotional validation is a primary way of building a rapport with BPD clients and may not be relevant for ASD clients.

Does accurate validation significantly reduce the client’s emotional arousal?

Lack of ability to identify and share emotions is a common feature of ASD. In BPD clients, childhood trauma or repeated invalidation can affect emotional recognition and processing (alexithymia).
Were the client’s family dynamics inhospitable to developing emotional recognition and naming skills?

Does the client’s emotional difficulties stem from a history of developmental neglect or trauma?

Physical proximity to other people may at times be an issue in ASD clients as well as BPD clients. This may be pragmatic in ASD clients (e.g. people are ‘in the way’) but more psychologically based in BPD clients.

Does the client experience post-traumatic symptoms from physical proximity?

Does the client have intense anxiety about judgments and criticisms of others?

Deficits in normal social engagement is a pervasive feature of ASD clients and may be a transient presentation in BPD clients related to dissociation.

Does the client have problems with going in to dissociative states?

Do the client’s social skills vary considerably depending on their level of anxiety?

Self harm in ASD clients can be associated with sensory overload and may be a communication about a problem (not exclusively emotional or interpersonal) while in BPD clients it tends to occur in the context of emotional dysregulation often connected to interpersonal conflict.

Does the client’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 the self harm for the client?

The relating pattern of attaching and rejecting is common in BPD clients. ASD clients will tend to have a more constant level of engagement. ASD clients may engage actively and then withdraw but for practical rather than emotional reasons.

Does the client have intense periods of emotional engagement with others followed by periods of being rejecting or withdrawing as opposed to a relatively constant level of engagement?

Is the pattern of the client’s way of relating largely because of emotional reasons or more for functional and pragmatic ones?

(ML and DK 2018)