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COMMENTARY

Engendering misunderstanding: autism and borderline personality disorder

Jay Watts

Queen Mary University of London, London, United Kingdom of Great Britain and Northern Ireland

ABSTRACT

Objective and Method: Female autism can be misdiagnosed as borderline personality disorder, leading to mistreatment and unnecessary harm. By educating clinicians on how female autism can mimic borderline personality disorder, we can increase the accuracy and effectiveness of diagnosis, ultimately improving patient outcomes.

Result: There is a common myth that clinicians can easily recognise borderline personality disorder, leading to a shortcut in the diagnostic process and the potential for missing signs of autism in early childhood.

Conclusion: Clinicians must be encouraged to pursue thorough differential diagnoses, especially for women and transgender individuals who experience emotional lability with self-harm.

KEY POINTS

- Autism is underdiagnosed in girls, women, and transgender individuals due both to diagnostic bias, and the quieter, less visible signs and symptoms of female autism.
- As females are so adept at camouflaging difference, distress generally only becomes manifest during mid childhood and adolescence, when mental illness gets misidentified as primary cause.
- Early mood difficulties often transform into more serious distress with emotional lability and self-harm. This can get misrecognised as borderline personality disorder, causing preventable harm.
- Borderline personality disorder is something that clinicians often feel they can recognise immediately, increasing the need to consciously think about differential diagnoses especially when presented with females who self-injure.

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Autistic women and transgender individuals often face misdiagnosis. International data suggests the average time between initial psychiatric evaluation and a diagnosis of autism spectrum disorder (ASD) is over a decade, with most patients receiving alternative diagnoses during that interval (Fusar-Poli et al., 2022). One of the most common and damaging misdiagnoses is borderline personality disorder (BPD) (Royal College of Psychiatrists, 2020). Why?

Autistic traits are present in early childhood but are not diagnosed until later, if at all. The likelihood of diagnosis varies according to class, ethnicity, geographical location, and, crucially, gender (Hull et al., 2020). Women and transgender individuals are routinely overlooked due to the male-biased phenotype to which parents, educators, and clinicians have been socialised (Lockwood Estrin et al., 2021).

The signs and symptoms of autism in women and Transgender individuals tend to be less visible and quieter, making them harder to detect for those who are unfamiliar with them. For example, they may have friendships in childhood, but these are usually limited to one or two peers and are marked by their intensity (Milner et al., 2019). Their 'special interests' commonly resemble girl-typical hobbies and their 'hyperfocus' is only noticeable when intensity, preoccupation, and endurance are carefully explored (Happé, 2019). Even patterns of 'stimming', 'burnout', and 'meltdown' are shaped by the internalising bias, making them less public (Lockwood Estrin et al., 2021). Girls are more likely to refrain from meltdowns until at home, or stim using small, less public movements.

The male bias means that autistic girls and Transgender individuals are less likely to be referred for assessment, with early problems commonly being attributed to shyness or something that one will grow out of. If they do manage to progress through the system and receive a formal assessment, they are subject to 'false negatives' as many of the most common assessment measures remain male-biased (Royal College of Psychiatrists, 2020).

Autistic girls and Transgender individuals tend to 'mask' more frequently and more effectively than their male counterparts (Hull et al., 2020), meaning they copy what other girls do consciously or unconsciously, often becoming adept 'mini psychologists' to mimic the rules of the social game. Parallel and dyadic play can also hide difference in early childhood, at least from adults.

Once children get older, they are subject to a heightened sensory environment that triggers increased likelihood of 'meltdowns', as well as more complex social dynamics where the subtext of speech becomes far more important and where rules become increasingly nuanced. Neurotypicals tend to say the opposite of what they mean, and even if this has been deduced, that extra level of computation is overwhelming. Puberty only adds to the difficulties (Milner et al., 2019), making even the body feel unpredictable and foreign, as does the increased likelihood of trauma (Happé, 2019).

It is generally only at this point in middle childhood and adolescence that distress becomes seriously problematic, seeming to resemble mental illness in form and timing (Royal College of Psychiatrists, 2020). Early difference commonly doesn't show up in history-taking, producing an iatrogenic insult that in itself becomes a risk factor for mental breakdown. Thus, secondary consequences are misread as primary cause, something patients tend to feel without a language through which to articulate it.

CONTACT Jay Watts clinic@jaywatts.co.uk Queen Mary University of London, London, United Kingdom of Great Britain and Northern Ireland

BPD is often given as a diagnosis as its symptom constellation so closely resembles the distress patterns experienced. BPD is a highly contentious diagnosis, characterised by intense and unstable emotions, a distorted sense of self, unstable relationships, and frequently, self-harm (Watts, 2019). Women are overwhelmingly diagnosed with BPD (75%), and it has repeatedly been seen as 'dustbin' diagnosis for traumatised females whom society find difficult (Hartley et al., 2022). BPD is one of the most feared diagnoses in psychiatry as it can be used to deny patients help and kindness, even when they have severe suicidal tendencies (Hartley et al., 2022). Due to its lack of construct validity, it was to be removed from ICD-11 until an eleventh-hour intervention when it was reintroduced due to political lobbying (Watts, 2019).

Although being autistic does not mean a person cannot have other mental health conditions, secondary diagnoses should be reliable, valid, and useful. BPD fails to meet these criteria and provides little, if any, additional explanation for many once autism is better understood. Consider this common pathway to misrecognition, frequently reported in clinics.

Autistic girls and transgender individuals' distress tends to start with increased anxiety, depression in mid to late childhood, with rituals and compulsions frequently used as an attempt to bring order to the world. Without support and understanding, individuals tend to resort to self-injury, such as cutting, to manage emotional dysregulation and sensory overload. These symptoms appear cyclical because masking is misrecognised as functioning well, meaning that responses like autistic 'burnout' seem to come from nowhere, or be excessive, to the neurotypical gaze. This provokes a punitive response from strangers, family, and clinicians, which becomes internalised and enacted on the self, in the following pattern:

1. *Masking* difference, which is extremely difficult to sustain
2. *Burnout, meltdowns, or self-injury,* which can lead to feelings of failure and further punishment, resulting in
3. *Mortifying guilt and shame,* fueling the need to mask their struggles once again

This pattern looks like BPD to most clinicians, especially given the autistic tendency to have one or two intense, close relationships. Once a patient is diagnosed with BPD, it is difficult to escape its explanatory reach. Stimming behaviours such as banging one's head against the wall or finger-flicking, for example, are commonly misread as self-injury or attention-seeking. This can direct the treatment to behavioural therapies that aim to 'extinguish' precisely what is keeping the individual together provoking a stand-off between clinicians and patients.

Gender bias and the templates that clinicians rely on to shortcut the diagnostic process disadvantage women and transgender patients here, over-presenting BPD as explanation and under-presenting autism. This effect is amplified by the widespread idea that clinicians have that they 'know BPD when they see it', a clinical myth bolstered by the similarity between the nosology of BPD and the societal trope of the attention-seeking, manipulative woman that most of us were brought up with (Lomani et al., 2022).

By taking a Sherlockian approach to diagnosis and unlearning our gender biases, we can help stop further iatrogenic harm (Courts & Tribunal Judiciary, 2022) and ensure accurate diagnoses. The stories of activists who have found recognition and acceptance of their autism to be life-affirming and even lifesaving after earlier being diagnosed with BPD serve as a beacon of hope (Cheryl, 2023).

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