



Diagnostic Complexity: Assessing the Intersection of Autism and Personality Disorders

Matthew Januzik, Psy.D.





Accuracy, Utility, and Risks Statement

This program **discusses recent research on ASD, PD's, and how to assess** for these disorders. Differential diagnostics is complicated, and this presentation will **not be able to account for other similarly presenting disorders** (i.e., ADHD, mood disorders, trauma disorders, etc.). Additionally, **providing assessment services requires an advanced level of training and education. This training alone is insufficient to provide assessments** for these disorders. Please **seek appropriate consultation and supervision** when using new testing measures. **Misapplication of the materials, or errors in using the materials, could result in non-compliance with applicable laws or ethics codes.** Clinicians are **responsible for practicing within the bounds of their own clinical competence** and following ethical and legal guidelines for the state(s) in which they practice.



Program Notices

No commercial support

No known biases

No conflicts of interest



AI Use Disclosure

AI was not used in the creation of this presentation.





About Me

- Matthew Januzik, PsyD
- Fuller Graduate School of Psychology & Marriage and Family Therapy (Pasadena, CA) - MA
+ PsyD in Clinical Psychology
 - Received training in assessment for pediatric neurodevelopmental disorders and therapy for adults with complex pathology.
- APA accredited internship at Wasatch Behavioral Health
 - Provided testing and therapy to individuals across the lifespan with complex diagnostic presentations.
- Currently a licensed clinical psychologist at UCEBT providing testing and therapy.



Overview

- Learning Objectives
- Overview of ASD and PD's
- Research on intersection of clinical presentations
- Assessment recommendations
- Therapy recommendations
- Case study
- Resources

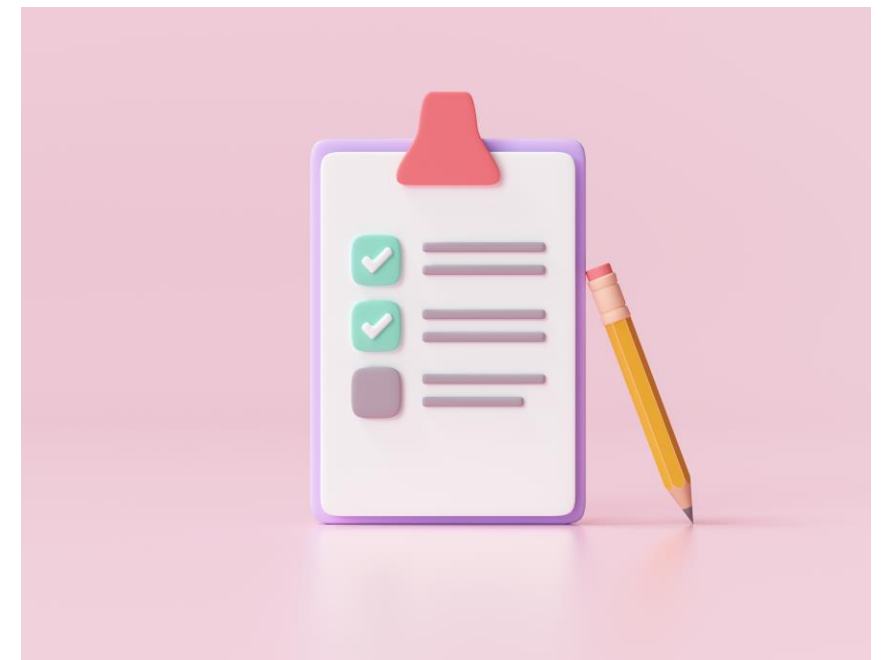


Learning Objectives

Describe similarities and differences in symptom presentations between ASD and at least two different personality disorders.

Identify two ways different cultural and contextual variables can impact the presentation of ASD and personality disorders.

List at least three testing measures you can use in assessing ASD and personality disorders.



Audience Poll - Background

Please type in the chat what your current professional role is (i.e., psychologist, therapist, social worker, nurse, teacher, etc.) or what led you to joining this presentation.



Audience Poll – Content Familiarity

Please type in the chat the letter associated with which of these presentations you are most familiar or comfortable working with/diagnosing:

- A. Autism Spectrum Disorder
- B. Personality Disorders
- C. Both
- D. Neither



Overview of ASD and PD's

- **Autism Spectrum Disorder background**
- **Personality Disorders background**



Autism Spectrum Disorder

- Neurodevelopmental disorder
- Persistent weaknesses in social communication and social interactions across various settings and situations that affect (3/3)
 - Social and emotional reciprocity
 - Nonverbal communication
 - Understanding, developing, and maintaining relationships
- Restricted and repetitive behaviors, interests, and activities (2/4)
 - Stereotyped or repetitive behaviors/speech
 - Inflexible routines and rituals
 - Restricted or fixated interests
 - Sensory interests or reactivity



Autism Spectrum Disorder cont.

- Prevalence rates range depending on study
- DSM-5-TR notes prevalence in US between 1-2%
 - DSM reports lower prevalence among women and racially and ethnically diverse children*
- CDC notes prevalence in US children around 3.2% and 3x more likely in boys
- Autism Speaks notes boys are 4x more likely, and lists higher prevalence in racially and ethnically diverse children
- Lots of research indicates girls/women are underdiagnosed
- Can be reliably diagnosed by age 2
- 5.0 is average age of diagnosis, 5.6 in girls



(American Psychiatric Association, 2022; Autism Speaks, 2026;
Center for Disease Control, 2025; Sarr et al., 2025)



Personality Disorders

- Longstanding patterns of experiences and behaviors
- Inflexible and pervasive across multiple settings
- Impact 2 or more of the following:
 - Cognitive beliefs
 - Emotions
 - Interpersonal relationships
 - Impulse control

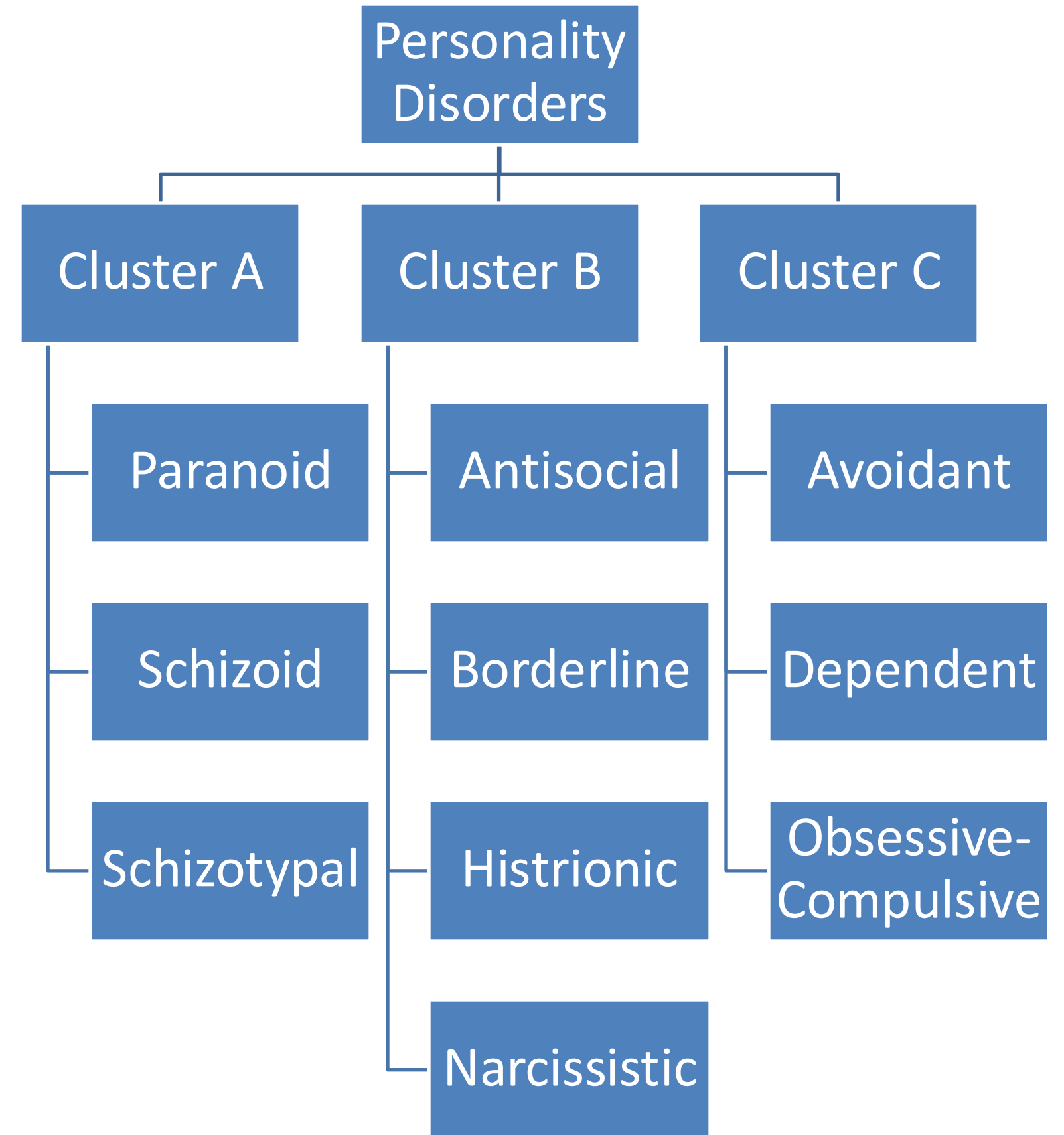


(American Psychiatric Association, 2022)



Personality Disorders cont.

- Prevalence rates range depending on study and specific disorder
- NIMH estimates 9.1% of population has a personality disorder, although data is old
- DSM-5-TR estimates 10.5% rate
 - Cluster A-3.6%
 - Cluster B-4.5%
 - Cluster C-2.8%
- Rates are higher in clinical settings (often around 11%)
- Identified in late adolescence or adulthood



(American Psychiatric Association, 2022; National Institute of Mental Health, 2007)

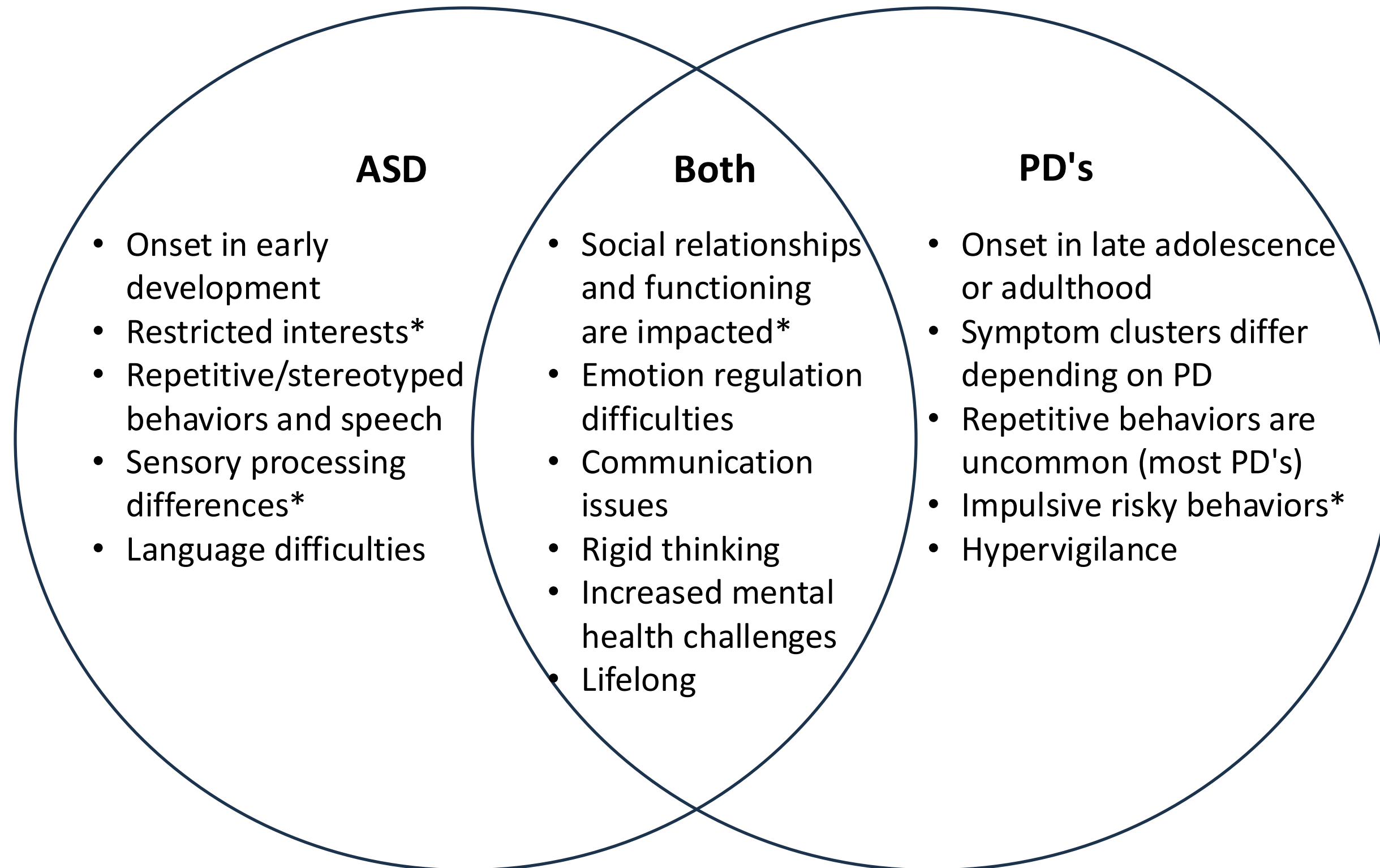


Audience Poll – What do you think?

Please type in the chat brief phrases or symptoms that you see as overlapping between ASD and PD's.

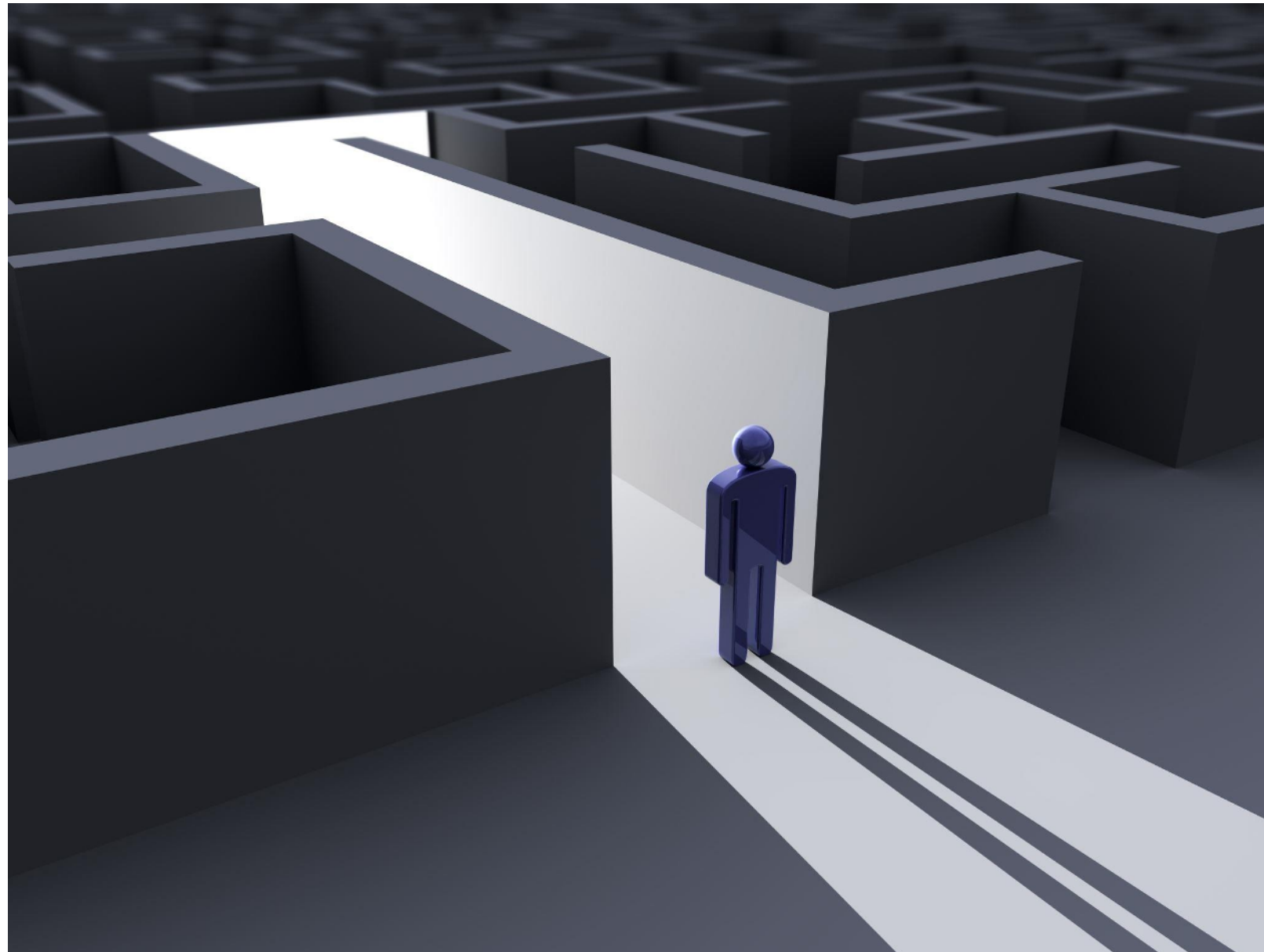


ASD and Personality Disorders





The Challenge



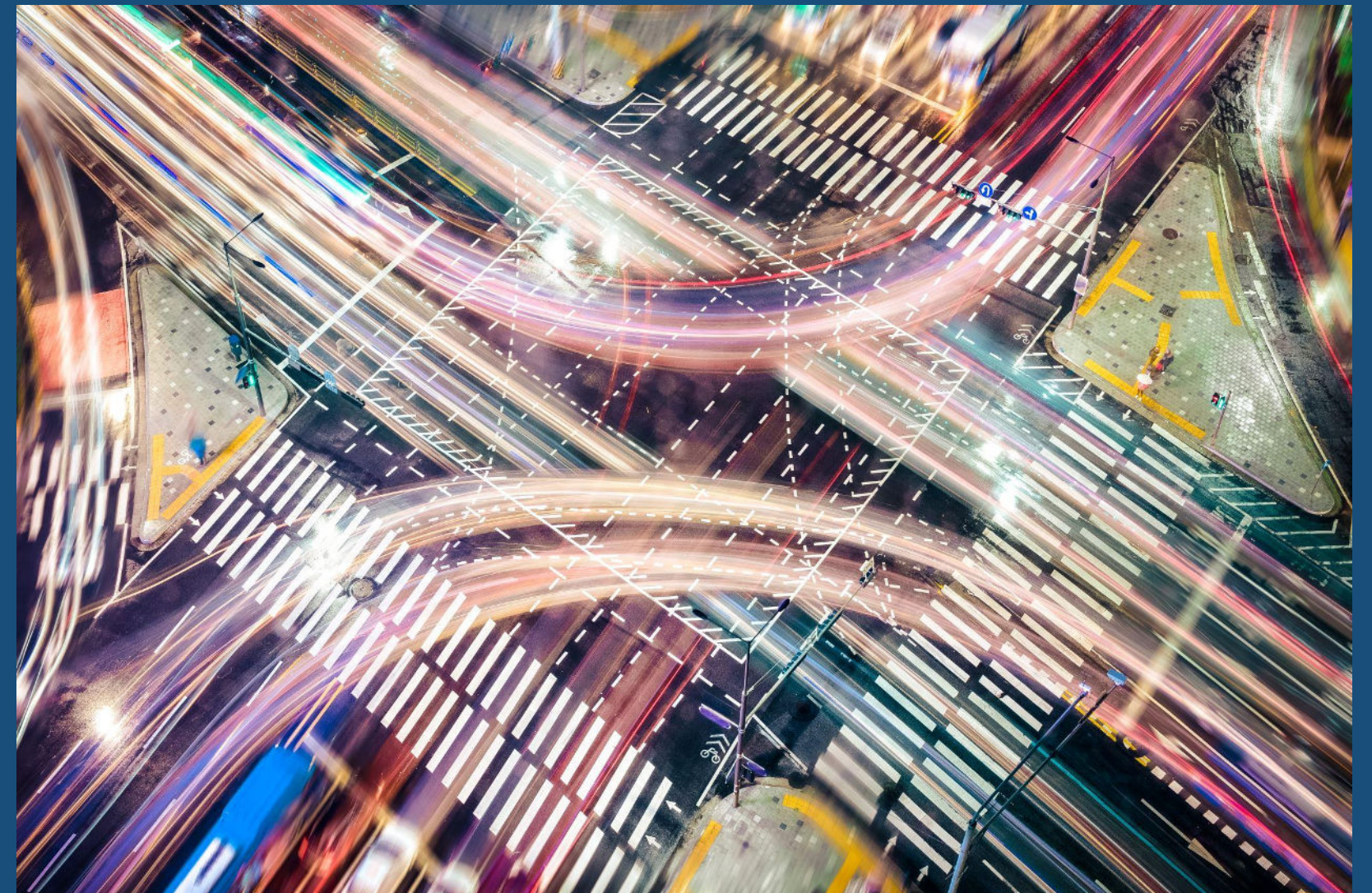
- Symptom overlap can be high, especially depending on the type of PD
- Misdiagnosis is common, especially in girls/women
 - Misdiagnosis leads to inappropriate and/or ineffective treatment
- Late diagnosis leads to more psychiatric conditions
- Limited literature and even more limited measures/testing practices
- Providers often trained and have experience with one or the other but not both
- Clinician biases can interfere

(Allely et al., 2023; Richards et al., 2023; Rinaldi et al., 2021; Sarr et al., 2025; Watts, 2023)



Research on Intersection of Clinical Presentations

- Overview
- Borderline PD
- Schizoid/Schizotypal PD's
- Avoidant/Obsessive-Compulsive PD's
- Limitations





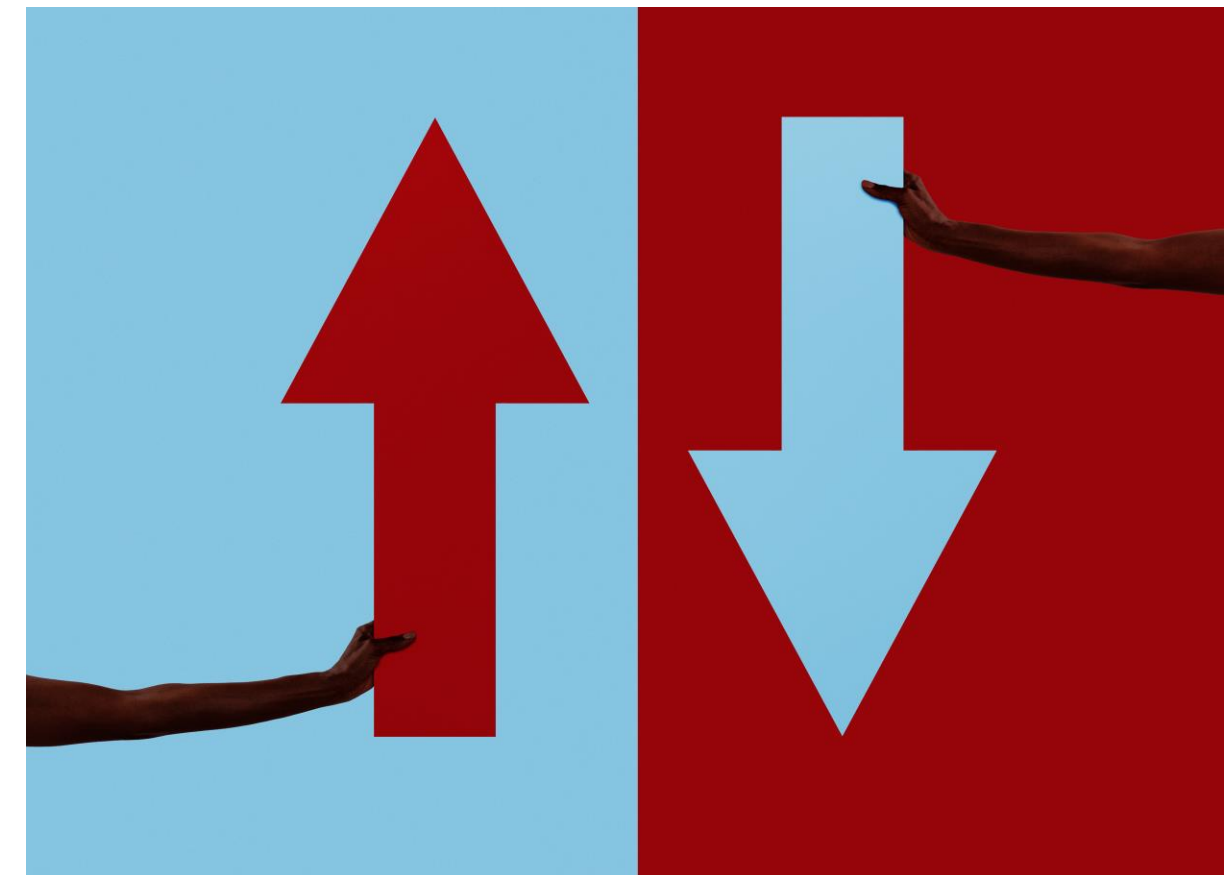
Intersection Overview

- Despite limited research, there are a handful of recent studies that have begun exploring this intersection, but the majority are focused on specific PD overlap (i.e., BPD).
- Other mental health conditions (e.g., ADHD, PTSD, OCD, etc.) can complicate the picture
- Research has typically been focused on high functioning ASD
- Research has also been focused on comparing ASD to specific PD's
- General considerations:
 - Cluster A-onset/prodromal symptoms, presence/absence of positive psychosis symptoms, social cognition deficits are a point of overlap
 - Cluster B-high focus on BPD, folks with ASD used less adaptive emotion regulation skills, misdiagnosis tends to be higher here
 - Cluster C-higher overlap of behavioral symptoms but the nature of the behavioral symptoms could be a differentiating factor



Other Personality Traits Interlude

- Big 5 Traits and ASD
 - Higher Neuroticism in folks with ASD compared to general population
 - Lower extroversion, agreeableness, conscientiousness, and openness to experience
 - Higher conscientiousness in folks with ASD than folks with BPD and NPD
- Broader personality traits
 - Higher social isolation and interpersonal difficulties
 - Higher harm avoidance, shyness, and pessimism
 - Lower levels of self-directedness and cooperativeness
 - Lower reward dependence, adaptability, and attachment
 - Lower novelty seeking



(Rinaldi et al., 2021)



Audience Poll – Co-Occurrence

Please type in the chat the letter associated with your personal/professional belief:

- A. Autism Spectrum Disorder and PD's can and do co-occur
- B. Autism Spectrum Disorder and PD's cannot/do not co-occur, it's one or the other
- C. I'm not sure if Autism Spectrum Disorder and PD's can co-occur
(please send help!)



ASD and Personality Disorders Co-Occurrence

Table 3. Personality disorders in the study participants with autism.

Personality Disorders Co-Occurrence in ASD (PD)	<i>n</i>	%
paranoid PD	19	5.7%
borderline PD	18	5.4%
personality disorder not otherwise specified	7	2.1%
schizotypal PD	7	2.1%
avoidant PD	6	1.8%
obsessive PD	6	1.8%
narcissistic PD	5	1.5%
schizoid PD	5	1.5%
aggressive passive PD	3	0.9%
histrionic PD	2	0.6%
dependant PD	1	0.3%
Total	79	24%



ASD and Personality Disorders Co-Occurrence



- Many of the studies suggest around a 40-60% co-occurrence rate
- Occurrence seems to vary based on type of PD, Cluster A and C have highest overlap
- Raises a question of is it misdiagnosis (e.g., ASD is not diagnosed and BPD is given instead) or actual co-occurrence
- Zavlis & Tyrer, 2024: "Personality psychopathology is an inherent feature of the autistic spectrum, but not vice versa."

(Allely et al., 2023; Gillett et al., 2023; Keller et al., 2020; Rinaldi et al., 2021; Zavlis & Tyrer, 2024)



Cultural and Contextual Variables



Gender

- The female elephant in the room
 - Women are underdiagnosed with ASD and misdiagnosed with BPD or other PD's often
 - Problems emerge in early adolescence, big emotions
 - Diagnoses of ADHD, MDD, GAD are common
 - Continued problems lead to increased behaviors, self-harm
 - Diagnoses of DMDD, IED, ODD, Conduct, Bipolar are common
 - Problems become more "longstanding" without resolution or appropriate treatment
 - Diagnoses of BPD or other PD's are common
- Multiple studies point to women with ASD having higher rates of BPD diagnoses than men with ASD
- Women with ASD present differently

(Gordon et al., 2020; Richards et al., 2023; Rinaldi et al., 2021; Watts, 2023; Zavlis & Tyrer, 2024)



Cultural and Contextual Variables

SES

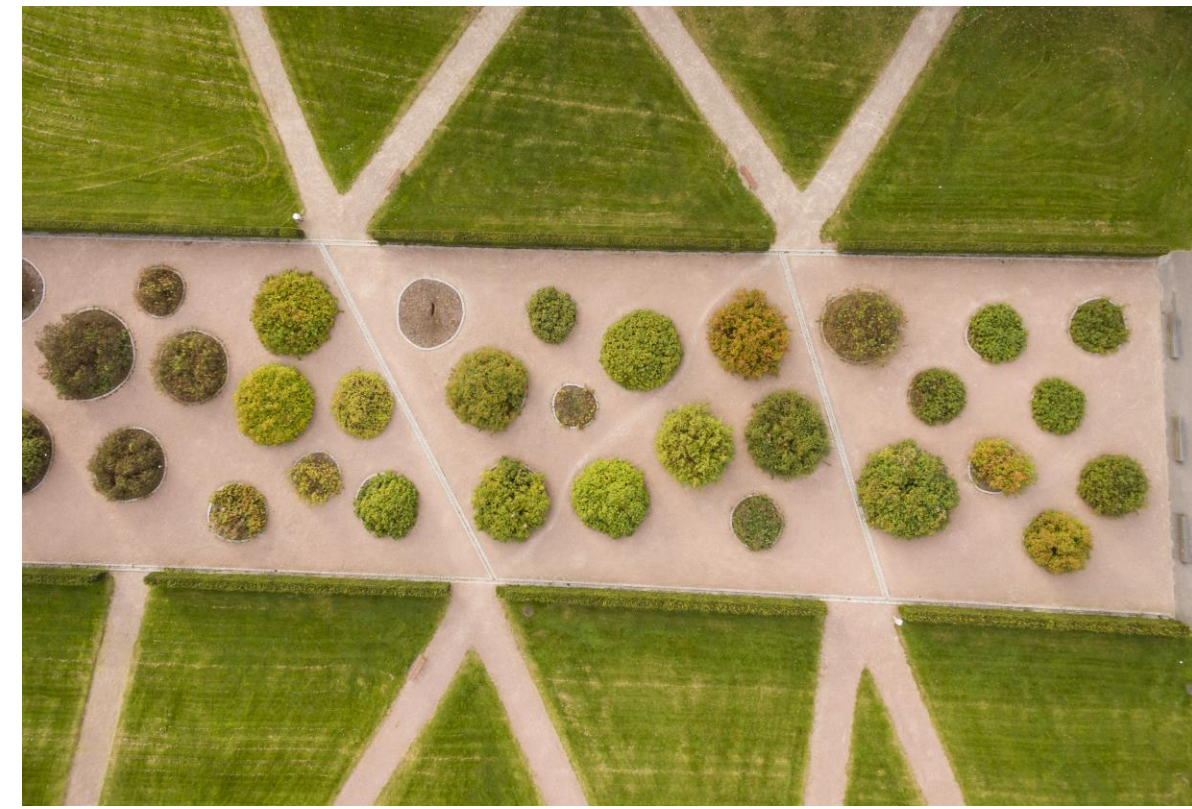
- Lower access to resources limits needed evaluations
- Higher SES = more likely to get an ASD diagnosis

Age

- People who go undiagnosed in childhood are at a higher risk of developing psychiatric disorders, including PD's, in adulthood

Race and Ethnicity

- Lack of literature addressing these variables
- Differing rates in diagnosing ASD in racial/ethnic minorities
 - Could lead to underdiagnosis
- One study found adults with autism were more likely to be diagnosed with psychiatric disorders than non-autistic adults across all backgrounds
 - Hispanic, Black, and Asian autistic adults were less likely to be diagnosed with a psychiatric condition than White autistic adults
 - Black autistic adults experience disproportionately more barriers



(Ames et al., 2022; Aylward et al., 2021; Becerra et al., 2014; Kentrou et al., 2021; Rinaldi et al., 2021; Sarr et al., 2025)



ASD and Cluster A

- The focus is on Schizoid and Schizotypal
- Schizoid
 - **Similarities** in social symptoms: social and emotional detachment and avoidance, poor social cognition, emotional blunting, odd communication
 - Research suggest around 20-30% co-occurrence in PD and ASD studies
 - **Differences:** Focus on prodromal symptoms and onset can be helpful in differentiation
- Schizotypal
 - **Similarities** in symptoms: unusual perceptual/sensory experiences, odd thinking and speech, restricted affect, social anxiety, reduced relationships, eccentric or repetitive behaviors
 - Potential genetic overlap
 - Similar **differences** as Schizoid, cause of social issues



(Allely et al., 2023; Booules-Katri et al., 2019; Gillett et al., 2023; Kendler et al., 2024; Rinaldi et al., 2021)



ASD and Cluster B

- BPD is the major focus
- BPD
 - **Similarities** in symptoms: social isolation, difficulties maintaining relationships, emotion regulation issues, identity problems, communication issues, sensory processing differences, difficulties managing unexpected changes, impulsivity*
 - Both carry increased risk for being abused and engaging in self-harm
 - **Differences:** causes in social isolation/avoidance, self-harm/risky behaviors
 - Less ASD-specific behavioral symptoms in BPD (restricted interests, stereotyped behaviors, desire for routine)
 - Evals for both often do not include the other
 - The Coventry Grid is a helpful tool
- NPD
 - Some research discusses difficulties in differentiating NPD from folks with ASD and high IQ
 - Behavioral symptoms are helpful in **differentiating**



(Allely et al., 2023; Gordon et al., 2020; Richards et al., 2023; Rinaldi et al., 2021; Sarr et al., 2025; Zavlis & Tyrer, 2024)



ASD and Cluster C

- The focus is on OCPD and Avoidant
- OCPD
 - Behavioral symptom **similarities** is limiting (rigidity, orderly, detailed)
 - **Differences:** ASD repetitive behaviors and restricted interests have a pleasure/mastery focus, OCPD symptoms tend to be more ego-dystonic*
 - May wish to consider OCD too
 - ASD is an overlooked co-occurring disorder for these folks
- Avoidant
 - **Similarities** in social symptoms: social avoidance, withdrawal, interpersonal relationship deficits
 - **Differences:** cause of social avoidance, behavioral symptoms
 - Examine fears around rejection, criticism, and disapproval



(Allely et al., 2023; Gadelkarim et al., 2019;
Gillett et al., 2023; Rinaldi et al., 2021)



Assessment Recommendations

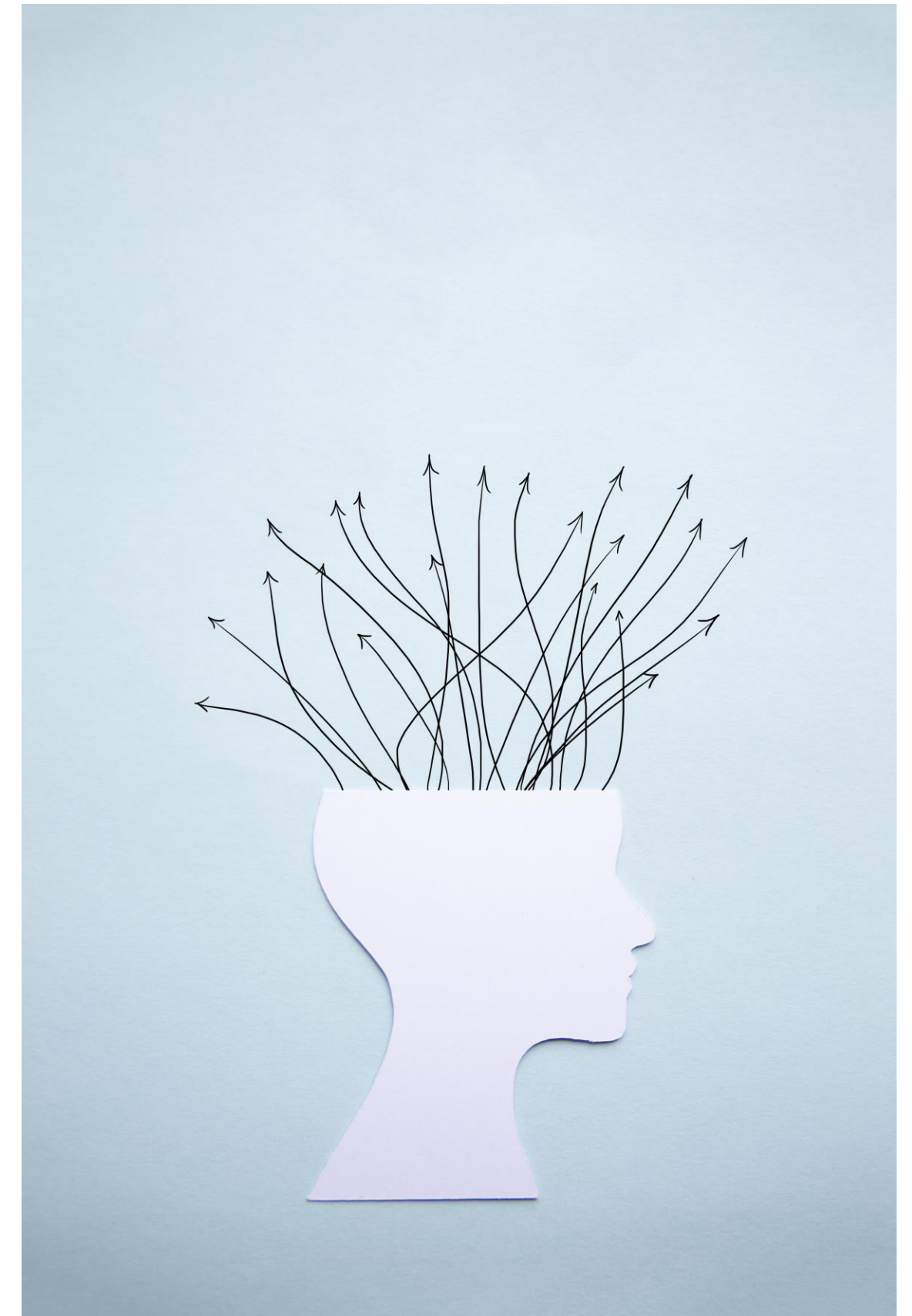
- **Autism Test Measures**
- **Personality Disorder Test Measures**
- **Clinical Interview**
- **Other Considerations**





Autism Testing Measures

- Use well-researched, evidence based ASD assessment measures within the context of a comprehensive evaluation
 - ADOS-2
 - ADI-R
 - AQ, EQ
 - CAT-Q
 - MIGDAS
- Do not solely rely on one measure
- Keep in mind the measures limitations (e.g., reduced sensitivity of diagnosis in adult women on the ADOS-2)
- Consider masking as a complicating variable
- Reliable diagnoses of ASD earlier in life can help prevent future diagnostic complexity



(Allely et al., 2023; Gillett et al., 2023; Rinaldi et al., 2021; Sarr et al., 2025)



Personality Disorder Testing Measures



- Include personality measures in your adult ASD batteries if you suspect a PD or if a PD has been previously diagnosed
- PD testing measure options:
 - SCID-5-PD
 - International Personality Disorder Examination (IPDE)
 - MCMI-IV
 - NEO-PI-R
- Some studies found that experts were not using any PD tools in their evaluations and were instead relying on gut opinion
 - Do not rely solely on observations or intuition!

(Booules-Katri et al., 2019; Gillett et al., 2023; Rinaldi et al., 2021; Sarr et al., 2025)



Clinical Interview

- Assess early developmental history (developmental delays, language issues, onset of behaviors)
- Get as clear of an understanding of the onset and trajectory of symptoms, particularly those potentially related to a PD
- Use personality measures to inform further interviewing of specific PD's
- Ask nuanced questions that get at the underlying cause of a symptom
- Ask after childhood trauma, relational trauma or instability, and neglect
- Check for family history of ASD



(Gordon et al., 2020; Rinaldi et al., 2021; Sarr et al., 2025)



Example Interview Questions

- Have you ever felt afraid that someone you cared about would leave you? Can you share some examples? If so, what have you done, and how often has this happened?
- Does you care about what people think of you? How do you feel when people praise you? Criticize you? Reject you?
- Do you tend to avoid tasks, jobs, or activities that involve a lot of people? Can you share some examples? What led to this avoidance/what felt uncomfortable about being around so many people? (probe for fears of rejection or criticism versus general social disregard)
- Do you find it challenging to work with other people if they do not do things exactly the way you would, or if they choose to do things in a different way from your expectations? Can you share some examples? Do you end up trying to do everything yourself to make sure it is done "the right way?"



Other Considerations

- Collateral interviews/information
- Behavioral observations
- Complicating diagnoses/factors (e.g., early childhood trauma, social deprivation, ADHD, psychosis)
- Cultural norms influence help-seeking and distress
- Formulation rather than assessment approach
- Hierarchical approach to symptoms
- Do not get hyper focused on one or two specific symptoms at the cost of the big picture
 - Look for symptom clusters
- Biases related to ASD versus PD's like BPD
- Keep in mind the length of waitlists for adults with ASD or PD's may affect presentation
 - Use your therapist skills!!



(Allely et al., 2023; Gillett et al., 2023; Gordon et al., 2020; Sarr et al., 2025; Zavlis & Tyrer, 2024)



Therapy Recommendations

- Screening Questions
- Therapy Adaptations
- DBT + RO-DBT





Screening Questions

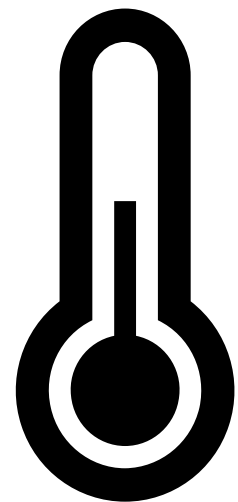
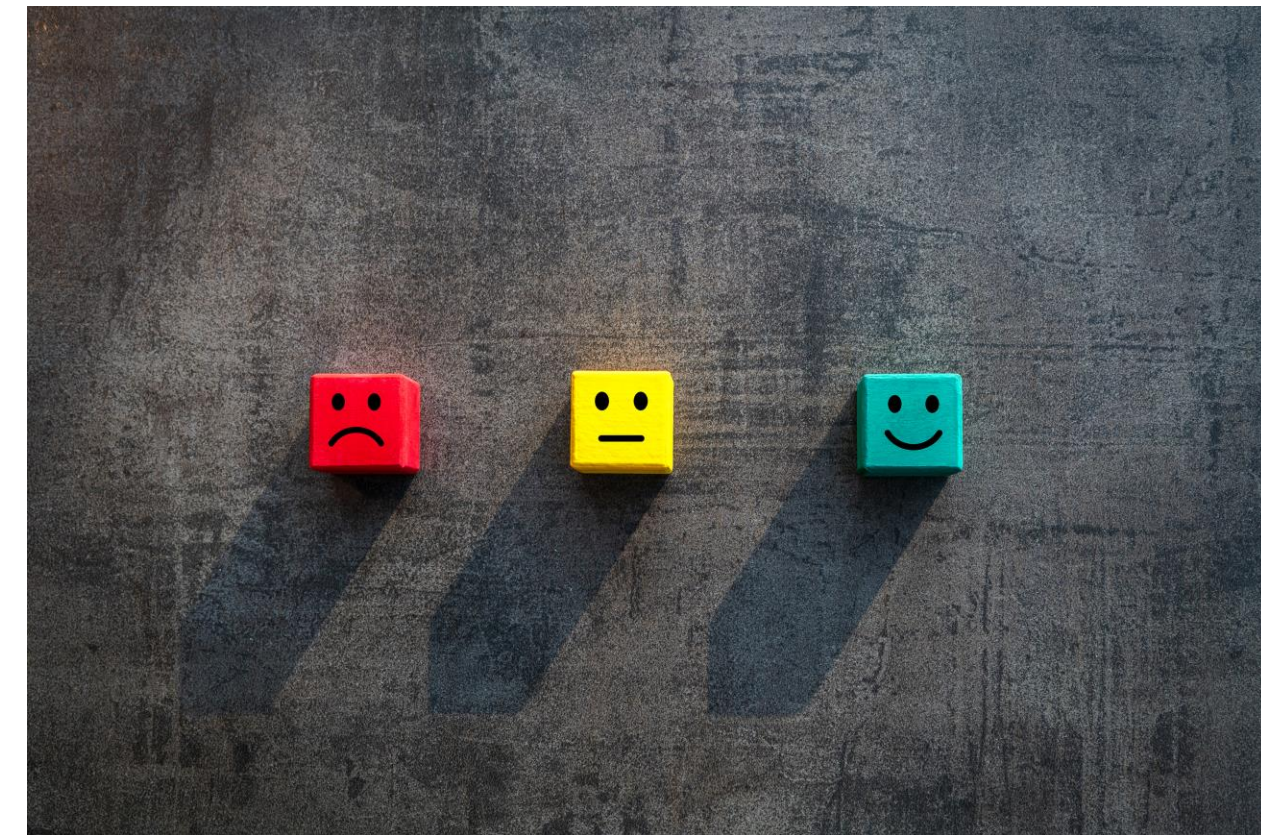


- Helpful to screen for symptoms if you suspect either ASD or PD's. Ask about:
 - Developmental history
 - Childhood experiences, trauma, neglect
 - Social weaknesses and causes
 - Relational patterns of attachment and rejection
 - Any unusual behaviors, sensory differences, rituals, interests
 - Symptom onset and trajectory
 - Patterns of self-harm or risky behaviors
 - Masking tendencies and social burnout
 - Experiences with past therapy and what worked
 - Use screening measures (AQ, SRS-2, SCQ)
- Refer for an evaluation if needed



Therapy Adaptations

- Folks with ASD would benefit from therapy adaptations, particularly when PD's are present
 - Stable and consistent therapy environment and sessions
 - Minimize overwhelming sensory stimuli
 - Address individual barriers upfront
 - Provide a structure at the outset of therapy and beginning of each session
 - Normalize emotions related to anxiety/social anxiety
 - Use cognitive strengths (e.g., visual cues)
 - Provide extra support on emotion regulation and identification
 - Use precise, clear, and simple instructions for psychoeducation, skills teaching, and homework
 - Plan support between sessions
 - Use specific interests as sources of examples or tools for coping





DBT + RO-DBT



- DBT
 - Emotion dysregulation in ASD is a major focus
 - Multiple studies found it was both feasible and satisfying to folks with ASD
 - Treatment adherence and retention higher than in controls
 - Adapt skills groups to ASD needs
 - Balancing acceptance and change can be validating for folks who mask
- RO-DBT
 - Targets maladaptive control which is common in ASD
 - Helped increase social skills and social signaling in particular
 - Weekly skills group was shown to be effective and enjoyed by patients

(Bemmouna et al., 2022; Cornwall et al., 2020; Ritschel et al., 2022)



Case Study Example – Jane Doe





Jane's Background

- 35-year-old, Japanese American, non-religious, heterosexual, cisgender woman presenting for ASD testing
 - Previous diagnoses include: MDD, PDD, GAD, PTSD, Bipolar I Disorder, and BPD
 - Married for 10 years with 2 kids (ages 5 and 7)
 - No friends or social support network currently
 - "Obsessed" with Barbies as a child
 - Repetitive pacing in childhood, and she would "moo like a cow" which she does to this day, but does not know why other than it "feels good to do"
 - Had two friends from elementary through high school
 - Sexual trauma in high school
 - Emotional outbursts led to multiple hospitalizations and outpatient therapists
 - Attempted college but dropped out due to feeling overwhelmed
 - Driftless and struggled with identity development
 - Unstable relationships until she met her husband



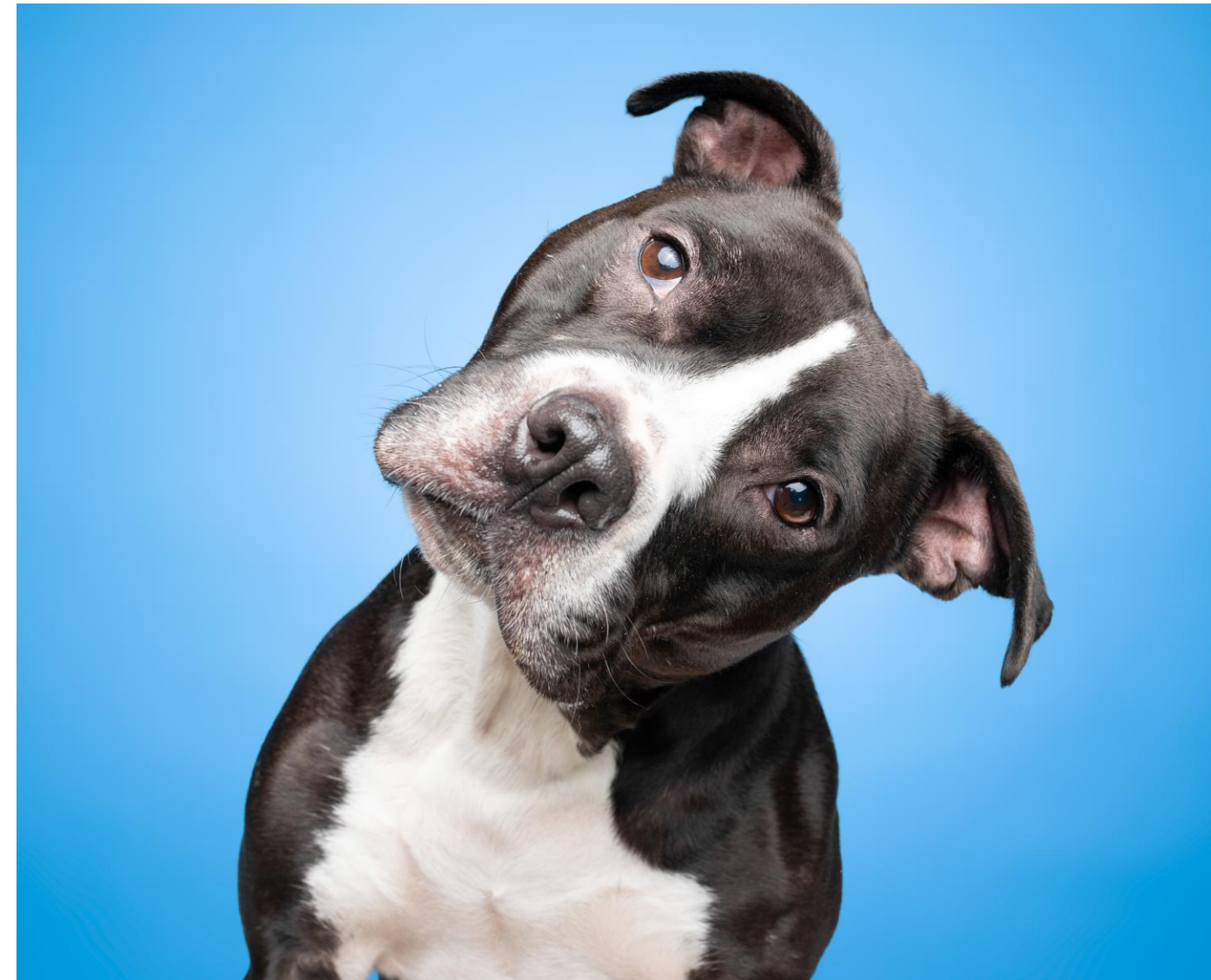
Jane's Testing

- Jane requested an evaluation to determine if she has ASD
 - Suspected it her whole life, but never diagnosed
 - Collateral interview with her mother confirmed social avoidance and some odd behaviors, but that was "just kids being kids" and she was "just a shy girl"
 - Elevated SCQ above cutoff
 - IQ was average
 - ADOS-2 results were just below the cutoff and in the "non-spectrum range"
 - SRS-2 completed by Jane and her husband were flagged in the severe range across all categories
 - MCMI-IV indicated very elevated levels of symptoms associated with Borderline, Avoidant, and Dependent traits
 - Depression, anxiety, and trauma symptoms were highly elevated
 - No mania endorsed
 - SCID-5-PD results were consistent with elevated Borderline traits



Audience Poll – What would you diagnose?

- Please put in the chat what your diagnostic conclusions would be!





Thank you! Questions?





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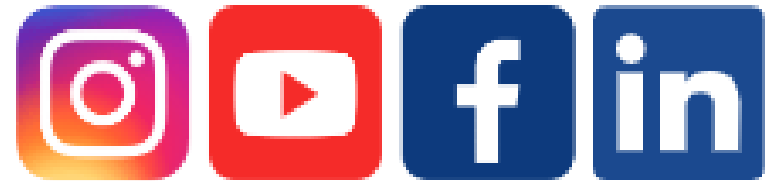


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