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Autism Spectrum Disorders and Borderline Personality Disorders: Comorbidity and Difficulty of Diagnosis in Women

Giuliana Galli Carminati[1,2], Gregory Zecca[3], Federico Carminati[2]

[1]Bundang Hospital, Seoul National University, Seoul, Republic of Korea
[2]International Society of Multidisciplinary Psychoanalysis, Geneva, Switzerland
[3]Independent Researcher, Lausanne, Switzerland
Email: giuliana.gallicarminati@gmail.com

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Abstract

Background: This paper addresses the challenges of diagnosing both Borderline Personality Disorder (BPD) and Autism Spectrum Disorder (ASD) simultaneously. We argue that this is particularly complex in women due to their tendency to engage in "social camouflage" behaviors, which mask underlying social difficulties. **Purpose**: Clinicians frequently encounter cases involving the co-occurrence of a personality disorder and another psychiatric condition. The comorbidity of ASD and BPD presents a unique challenge, as both disorders involve emotional dysregulation, sensitivity to rejection, and difficulties in social relationships. Women, in particular, often demonstrate better social adaptation or "camouflaging" of symptoms, which can obscure accurate diagnosis and hinder treatment. This paper aims to raise awareness among therapists about the need to consider this dual diagnosis and suggests some therapeutic avenues for treatment. **Methods**: We review and analyze the existing literature on this topic, followed by the presentation of two anonymized clinical cases from our practice. Through the exploration of these cases, we illustrate the difficulties faced by patients, their families, and therapists when managing ASD and BPD comorbidity. **Results**: Practitioners may initially focus on diagnosing and treating BPD, but the concurrent presence of ASD can complicate the patient's well-being and create additional challenges for the family and the entourage. The cognitive fatigue that individuals with ASD experience during social interactions can exacerbate BPD symptoms and impede therapeutic progress. Therefore, therapists must carefully consider the possibility of this dual diagnosis, especially when treating women with borderline traits.

Keywords

Autism Spectrum Disorder, Borderline Disorder, Comorbidity

1. Introduction

The purpose of this article is to raise awareness among clinicians on the simultaneous presence of autism spectrum disorders and borderline personality disorder, with particular attention to female patients.

One of the authors, during her past clinical practice with intellectual disability, noticed that therapeutic approaches used in day hospitals were similar for both Autism Spectrum Disorder (ASD) and Borderline Personality Disorder (BPD) populations with varying degrees of intellectual disability. Observing a similar therapeutic trajectory in these diagnostically different populations led to further reflection and continued clinical practice with a population having average intellectual capacities with ASD or BPD.

In BPD patients, we observed emotional and sensory dysregulation, difficulty in imagining what others might think, self-injurious behaviors, and very low self-esteem. These symptoms are also present in patients diagnosed with Asperger's syndrome.

The scientific literature confirms these observations. The relationship between ASD and BPD has attracted considerable attention due to shared features like emotional dysregulation and social challenges (Cheney et al., 2023; Dell'Osso et al., 2023; May et al., 2021). While distinct, both conditions may overlap in various areas, supported by several theoretical frameworks (Allman et al., 2024).

Both ASD and BPD involve difficulties with emotional regulation. In ASD, this may stem from sensory sensitivities, while in BPD, it is linked to relational trauma or attachment issues (Yuan et al., 2023). However, although ASD is a neurodevelopmental condition, individuals with ASD are more likely to experience bullying, social exclusion, and other forms of trauma due to their social communication difficulties, which may exacerbate emotional dysregulation (Rodriguez, 2022).

From the cognitive standpoint, there is also substantial overlap between the two conditions. Both disorders exhibit challenges in understanding others' perspectives. ASD often involves deficits in the patient's Theory of Mind, while in BPD, it may arise during emotionally intense situations (Fonagy & Bateman, 2007; Vegni et al., 2021). Individuals with both ASD and BPD can exhibit traits of cognitive rigidity, with black-and-white thinking—routines in ASD and dichotomous thinking in BPD (Allman et al., 2024).

Neurobiological studies show that both ASD and BPD are associated with abnormalities in brain regions linked to emotion regulation, such as the amygdala and prefrontal cortex (Geurts et al., 2022; Wang & Li, 2023). Serotonin dysregulation also plays a role in both conditions (Del Casale et al., 2021; Rodnyy et al., 2024; Wang & Li, 2023).

Attachment issues and social challenges are present in both populations. BPD is linked to attachment insecurity and unstable relationships, while ASD involves social communication difficulties. Both can lead to relationship struggles (Rodriguez, 2022). We will expand on some of the above points later in the paper.

A recent extensive literary review (Dell'Osso et al., 2023) documents the

presence of comorbidity and superposition of the two disorders but also, interestingly, a significant presence of below-threshold autistic symptoms in the BPD population. While there is no evidence of a causal correlation between ASD and the subsequent development of BPD, the simultaneous presence of both syndromes may worsen the patient's situation and prognosis.

This paper focuses on women since, due to both syndromes' specific history and epidemiology, the ASD BPD comorbidity presents particular therapeutic challenges for the female population. BPD has long been perceived to be a female-predominant disorder in both research and clinical contexts, even if recent studies seem to challenge this assumption (Qian et al., 2022). Moreover, ASD seems to be underdiagnosed in women (McCrossin, 2022; Neighmond & Greenhalgh, 2017) due to "social camouflage." Women with ASD may appear to have fewer social difficulties, not because they experience less but because they are better at camouflaging their challenges (Dell'Osso et al., 2021, 2022; McQuaid et al., 2024). The combination of these two factors may lead to a massive underestimation of the ASD BPD comorbidity in women, with adverse effects on their treatment and prognosis.

Social camouflage may temporarily offer good social acceptance, but in the medium term, it leads to severe intellectual fatigue, stress, anxiety, and depression (Dudas et al., 2017; Hull et al., 2017; Willey, 2015). The camouflage typically present in female ASD often results in artificial and dramatic expressiveness and an inadequate communication style, also typical of BPD. In addition, eating disorders, anorexia, and or bulimia, frequently present in both syndromes, can be a specific form of limited interest. The frequent presence of eating disorders in both populations can orient their diagnosis and treatment toward their reconceptualization as manifestations of a neurodevelopmental disorder (Carpita et al., 2022; Pini et al., 2016). In this sense, failure to detect autistic disorder in women can lead to a misdiagnosis skewed towards eating disorders and PBD (Soloff, 2000).

Other authors, in a study on the female population with both diagnoses, highlight a possible lack of mentalization, which is not incompatible with compensating hypersystematization (Rydén et al., 2008). Low empathy and high systematization are also emphasized in the study by Dudas et al. (Dudas et al., 2017), and López-Pérez (López-Pérez et al., 2017) highlights the lack of Theory of Mind in these two populations. Anckarsäter et al. (Anckarsäter et al., 2006) point out that a developmental disorder such as ASD, if not diagnosed early in childhood, can be identified as a personality disorder in adulthood. Nanchen (Nanchen et al., 2016) note lower EQ (Empathy Quotient) scores in the ASD and ASD + PBD groups compared to the PBD group but higher systematization scores (SQ-test) in the ASD and PBD groups. Their remarkable ability to systematize suggests a compensation mechanism for both groups' high emotional instability.

In the autistic population, alexithymia and anxiety are almost always present (Afif et al., 2022; Hollocks et al., 2019; Kinnaird et al., 2019; Poquérusse et al., 2018) and show how poor the understanding of one's emotions is. Patients with

BPD have difficulty understanding their own emotions, albeit in a more theatrical and excessive mode (Edwards et al., 2021).

Raising children and adolescents with ASD is a challenge for parents and an additional source of strain compared to parents of children with neurotypical trajectories (Ni'matuzahroh et al., 2021; Pastor-Cerezuela et al., 2016). These parents present poorer coping skills associated with a lower quality of life, resulting in difficulties in children's education. We think that a lack of understanding of the offspring's atypical functioning can lead to adjustment difficulties between parents and children with ASD. Misunderstanding ASD leads to discrepancies between parents' educational practices and the specific educational needs of their autistic child. The education of a child with ASD also involves the complex management of so-called "challenging" behaviors such as irritability, anxiety, or noncompliance (O'Nions et al., 2018). This mismatch between parents' expectations and children's mental working can lead to various forms of educational violence with a stressogenic and sometimes traumatic impact on the development of the ASD individual. This disharmony between environment and individual—as postulated by the temperamental theories of Thomas and Chess (Thomas & Chess, 1977)—can lead to the appearance of additional symptoms and, eventually, to complex developmental traumas, especially if parents develop repeated coercive educational practices out of exhaustion. It is conceivable that children and adolescents with ASD may not respond to their parents' educational incentives as well as neurotypical children and, therefore, induce the parents to be more severe and aggressive. This misunderstanding of the ASD child-specific needs and the consequent communication detuning between parents and their children may promote the emergence of borderline and specific character traits. Some experiences can also be a source of great stress and, if misunderstood, induce aggressive reactions from the person with ASD. For example, the onset of menstruation and the associated hormonal changes can generate such discomfort in ASD women (due to their hypersensitivity) that they develop aggressive behaviors towards those around them. If not understood by the entourage, these reactions can become chronic and elicit a borderline response when facing future discomforts.

While this paper focuses on ASD BPD comorbidity in women, studies on men with ASD and BPD have shown that comorbidity also leads them to increased difficulty in managing emotions and interpersonal relationships (Bemmouna et al., 2023). Although less studied, men with ASD might camouflage through different strategies compared to women (Wood-Downie et al., 2021). For example, while women may mimic social behaviors and emotional expressions, men may avoid social situations altogether or conform to stereotypical male behaviors like appearing emotionally distant. These forms of masking can lead to missed or incorrect diagnoses of both ASD and BPD in men.

We wrote this paper with the intent to help therapists treat women presenting an ASD BPD comorbidity. As we explained, this population is particularly challenging since ASD tends to be underdiagnosed in women, leading to an

underestimation of the continuous strain to adjust to social norms for these patients. If BPD is also present, the patient's coping ability and resources are seriously compromised, and this makes diagnosis and treatment even more challenging.

2. Clinical Vignettes

We present now two cases illustrating how the overlap between ASD and BPD can manifest itself in actual clinical situations. While anecdotic, we believe these two vignettes well represent the ASD BPD comorbidity amply discussed by the literature. These vignettes intend to provide realistic examples of the progress of therapy with ASD and BPD patients. The timeline of the stories is not linear since the patient's past is not all described in the initial anamnesis, but it emerges progressively. Even if this presentation may be hard to follow, it better reflects what a therapist faces when dealing with these patients.

2.1. Vignette 1

This vignette tells the story of a patient we followed in our practice for several years, who has given her consent that we present her situation as a clinical example for this article. Mrs. Forli (not her real name), a woman in her fifties, consulted at our practice following a referral by the public mental health care network after a lengthy hospitalization in a psychiatric unit. Ms. Forli had been repeatedly hospitalized since her mid-thirties when she began receiving a 100% disability pension. At the start of her psychiatric and psychotherapeutic follow-up, she was divorced and the mother of two children in their late teens and early adulthood. During the six years of her psychiatric treatment, she attended weekly psychotherapy sessions, and she also joined a support group for patients with social difficulties, partly covered by her disability insurance.

Mrs. Forli studied architecture but abandoned this career to train as a surveyor. However, after graduating, she practiced this profession only for a couple of years. She worked as a secretary for several years until her thirties, when her mental disorders prevented her from continuing.

Throughout her care pathway, she received several diagnoses, including borderline personality and schizoaffective disorder associated with a recurrent anxious-depressive disorder. Before arriving at our practice, Mrs. Forli had several psychiatric and psychotherapeutic follow-ups as an outpatient. Given her triple diagnosis, we considered that what she referred to as "voices"—previously thought to be auditory hallucinations—was more likely a cycling internal dialogue that intriguingly resembled a mental loop.

Mrs. Forli often arrived at our meetings anxious about her administrative and household chores. She lamented her mental state and chronic fatigue, which paralyzed her decision-making process. She complained a lot about hearing voices, especially when waking up—which led to her diagnosis of schizoaffective disorder. During the first months of follow-up, after we suggested a connection between her

daily experiences and her anxieties, she would call us in a state of crisis several times a week. She experienced a disconnect between her different emotional experiences. For example, while suffering from breast cancer, she could not relate her anxieties and crises to her appointments at the oncology department. As the follow-up progressed, she improved her ability to manage the stress caused by our interpretations, and the number of crisis calls decreased. She experienced anxiety whenever she felt abandoned, especially when her children did not respond to her emotional distress or when they went on vacation. In addition, she struggled to find an occupation, which, after a few months of follow-up, led her to attend an occupational day center three days a week, where she could engage in activities related to sewing.

Some elements led us to suspect the presence of a mild ASD associated with attention deficit hyperactivity disorder (ADHD). ASD was assessed via a battery of tests developed by Baron-Cohen (Woodbury-Smith et al., 2005), and we determined the presence of BSD via the French version of the Borderline Personality Questionnaire (BPQ) (Larivière Erg et al., 2021). We assessed ADHD symptoms and associated problems with a protocol developed by the Canadian ADHD Resource Alliance (CADDRA, 2017). Ms. Forli appeared to have interpersonal difficulties due to a lack of understanding of certain aspects of social communication and challenges with the Theory of Mind. In addition, she exhibited a "spiraling discourse," frequently repeating herself during sessions and bringing up the same topic week after week. She reported difficulties concentrating on tedious and repetitive tasks, such as washing dishes and maintaining sustained attention, which are common symptoms of ADHD. In particular, she complained that she could not focus on reading a book alone at home. She also had mental hyperactivity with a tendency to ruminate at length, fueling her anxieties and depressive symptoms. She was prone to binge eating. The lack of a "framework role" was a problem for her. Indeed, she reported being well organized when she worked or had to take care of her children during compulsory education. The reduction in the number of daily chores led to an increase in some of her symptoms.

A more detailed anamnesis of her childhood and school years revealed elements suggestive of a developmental disorder. Ms. Forli experienced a good relationship with her parents. However, she had difficulties understanding the social world, which she experienced differently from most people, with a tendency to social camouflage, over-adaptation, and naivety characteristic of autistic functioning. Her parents did not seem to perceive these aspects, and she had difficulty expressing her needs clearly to them. As a result, she ended up ignoring—cutting herself off—her desires and needs not to upset her parents. For example, during puberty, she had to spend long hours studying with her mother (a foreign-trained academic who could not teach in Switzerland). Every Thursday (the day of the week with no school in Switzerland in the 1970s), when she wanted to play with her classmates, she was forced—and felt obliged—to attend her mother's private lessons without ever showing a sign of teenage rebellion. Since then, Mrs. Forli has inhibited

her wishes not to disappoint others, repressing her identity. This self-imposed sacrifice caused her repeated traumas, with a chronic—and exhausting—psychic wear and tear.

She behaved the same way with her peers, which may have contributed to the appearance of fear of abandonment traits, particularly during separations from her friends (such as those that can occur with changes in school or class levels). She thought she was fooled in her friendships and romantic relationships as a young adult during this period and even beyond. Her naivety and inability to assert herself in relationships may have opened the door to abusive social situations with medium long-term traumatic effects. This constant strain of feeling "out of step" with her world may have favored the appearance of the personality disorder.

The therapeutic approach we followed for this patient was to continue the pharmacological treatment prescribed by her previous therapist, adjusting it to her evolving situation. We started psychodynamic-oriented psychotherapy mainly to support her in her daily life and help her reconnect with her feelings. We also encouraged her to find occupational activities to find an alternative "framework" for her daily routine since she had no employment and did not have to care for her children.

2.2. Vignette 2

This vignette does not tell the story of a specific patient but is a synthesis of different clinical situations encountered by the authors. The clinical history that emerges is paradigmatic of the diagnostic obstacles often confronting people with ASD and BPD.

Mrs. Samhir is a woman in the second half of her fifties, elegant with a slightly dated 80s style, slender, and somewhat tense. She requested an appointment after a rest stay in a semi-medical spa center. Mrs. Samhir complained of being tired and in bad shape, even if the stay was pleasant. She told us that, for ten years, she felt in eternal convalescence.

The reason for requesting an appointment came from her reading of some of our articles on autism spectrum disorders. Mrs. Samhir is a trained chemist and worked for ten years in a large pharmaceutical company before joining a consulting center, where the atmosphere seemed less stressful. When we first met her, she had been out of work for over twelve years. A very long sick leave followed by a dismissal letter ended her last employment. She did not try to find another job. Indeed, her situation was much more complicated and challenging, but this will come to light later in her story.

Mrs. Samhir had a long history of psychotherapeutic follow-ups with various approaches. Her therapy began in childhood, was interrupted during adolescence and early adulthood, and resumed intensively after her divorce. She also tried meditation and natural medicine, and had various pharmacological treatments.

Her last psychiatrist, soon to retire, advised her to continue her therapy with a colleague. Mrs. Samhir said that she felt abandoned while understanding his

reasons and held a slight grudge against him.

Mrs. Samhir has been divorced for ten years. Her two children, a girl and a boy, are adults, and she has four grandchildren whom she sees occasionally. When asked if she currently lives with a partner, Ms. Samhir says that she is not seeking a relationship, not because she is not interested, but because she fears that she will not be able to manage a partner in her life, which she experiences as already far too complex. She has been living for a few years with a woman of the same age with whom she now shares a deep friendship and a bond of mutual aid that she defines as essential to survival.

Her ex-husband, a businessman of North American origin with an excellent economic situation, no longer has any contact with her. The marriage, which lasted almost three years, was often conflictual but even more often solitary because Mrs. Samhir lived a form of celibacy with children rather than a life as a couple.

Mrs. Samhir admits that she is terrified of drugs in general, her past as a chemist having something to do with it, and that she is especially wary of anxiolytic drugs because of the possible addiction they generate. Still, she admits that without "her fix"—as she describes her attitude towards the drug—she can no longer live properly, becomes tense and irritable, gets into conflict with the neighbors, and can no longer manage her daily life.

After some appointments, we settled on a fortnightly session schedule that Mrs. Samhir attended regularly. She also took very regularly her antidepressant treatment.

Mrs. Samhir had a problematic relationship with her parents. Her marriage was a symptom of this since she admitted that she decided to marry her ex-husband to upset them because they found his social status and mentality too distant from theirs. They would have preferred "a good traditional marriage with a good Swiss from here." On our part, we feel that Mrs. Samhir made a love marriage, perhaps even too much, that she was passionately attracted to this man who came from another universe, and that she needed to free herself from a family and social constraint that weighed heavily on her.

Looking back, we find in this woman—brilliant in her studies—a great anxiety related to parental pressure for academic success.

As the therapy progresses, Mrs. Samhir tells us about her heartbreaking fears when entering class and her continual flight to withdrawn and impulsive behaviors when pressure and stress became too strong.

Happy in her small early childhood school, where she knew her friends and teachers, she experienced a tidal wave of anguish when it was time to change schools. Much later in therapy, Mrs. Samhir revealed that in her small primary school, she was allowed hours to perfect her drawings and to be alone in her corner to daydream when she needed solitude.

She regularly made the journey to the new school in tears. In front of the classroom door, she felt that the gaze of others would crush her, feeling like she was in

a tribunal rather than a children's class. The story of her school experience surfaced after a few months of therapy, and she relived it several times as if, deep down, time had never passed and the child in front of the door had become an adult with adult's words, but inside remained forever a broken child. Although the term "tribunal" is not typically associated with children, as they rarely appear before a judge, the adult before us perpetually relived a story filled with overwhelming fear of being judged by others.

Mrs. Samhir spoke of school psychologists without aggressiveness. They were all women, and she found them welcoming and kind, but she refused their advice to repeat the class. Mrs. Samhir, being "good at school," did not want to lose her friends again, although she feared them so much. In a miracle of incoherence, this child suffered martyrdom but wanted at all costs to "be normal" and found good in her suffering.

Continuing the story of her studies, Mrs. Samhir told us that she had graduated with good grades from the Department of Chemistry. Ms. Samhir admits that during her final year, with a very dense laboratory schedule and the diploma thesis to write, she found it challenging to concentrate and find the energy to finalize her studies.

Mrs. also felt abandoned by her family, who seemed to be just waiting for the diploma "to get rid of her," to the point that she felt that even the party following her defense was fake.

We tried to relativize these assertions but felt that Mrs. Samhir had an all-or-nothing attitude. When she believed she had everything, she was euphoric; but when she feared she had lost it all, she descended into despair. There were no half-measures. In any case, Mrs. Samhir simply could not understand how to perceive reality—internal or external—in half-measures.

Mrs. Sahmir found a well-paid job without too many problems and climbed the hierarchy ladder during the first five years. Then, she began to lose momentum, multiply conflicts with colleagues and the hierarchy, experience relational difficulties, and become bored at work. Her career eventually slowed down to a dignified but terribly boring siding.

Both pregnancies had gone well, but it was evident that her husband had a vision of a couple where the wife took care of the children and the house, and it did not matter if she earned a salary and, with it, a measure of economic independence. He was convinced to be the head of the household and a successful career person.

The lack of dialogue and the profound loneliness felt by Mrs. Samhir had made her decide to separate and divorce, which her husband too very badly.

In this challenging moment in her marriage, Mrs. Samhir decided to leave her employer and found a new job in a Consulting Center. This less demanding activity with fewer prospects seemed to her a good compromise to manage her family, the children's education now weighing entirely on her shoulders. Mrs. Samhir told us that she had questioned herself at length about her decisions, first of separation,

then of divorce and change of job. She told us that she had sought to protect herself from her couple problems and sidelining at work by choosing a family life without a husband and a seemingly less frustrating job.

Managing the children, mostly on her own, had been a heavy burden, and the job—intended to be less frustrating—had become a trap, offering lower income and just as much stress.

Exhaustion had won over her fierce desire for economic independence. Mrs. Samhir had obtained loss of earnings insurance coverage with which she could have lived with dignity for at least two years. Still, she had lost it on a whim by refusing to go to appointments with the psychiatrist because she considered her therapy, in the end, useless. Her ex-husband provided her with an acceptable economic situation while keeping an icy distance that had hurt her terribly.

The children, once adults, seemed to choose the father's side and found her sad and without impetus, which Mrs. Samhir felt was unfortunate and unjust.

Mrs. Samhir took her little children into her house occasionally, on certain weekends or Wednesdays, which are days off from school. She says she is happy to take care of them but admits to arriving in the evening exhausted, not only because the children are children and some are already in their pre-adolescence and others are still very young, but because she feels saturated with their presence, needing tranquility and withdrawal.

The main subject of most of the session was to help her manage daily life, support her with administrative difficulties, and help with family relations.

The diagnosis had not been our first concern. The problematic impulsivities in social, family, and, previously, at-work interactions evoked a BPD, which was also mentioned in the reports to the health insurance written by her former psychiatrist.

With more time to dedicate to a psychodynamic anamnesis, we noticed that the bond with her parents remained very fusional, typically with an exacerbated conflictuality with the mother and an intense jealousy towards the brothers and sisters of whom she was the youngest. Mrs. Samhir felt unloved by her mother and the unwelcome little brat for her brothers and sisters. These sentiments are pretty frequent. Everyone, at least occasionally, experiences profound jealousy towards siblings, the oldest or the youngest. For single children, it becomes complicated because the little brothers and sisters are imaginary and, therefore, even more dangerous. What gave us a hint was the description of specific difficulties in childhood, the impossibility of interacting in games, and a strong tendency to isolate herself. Homework was difficult to start, there was a sense of procrastination throughout the school career, and the teachers had reported very significant anxiety, marked attitudes of withdrawal, and excessive perfectionism.

As the work of introspection progressed—and it became clear that Mrs. Samhir had a long habit of it—emerged episodes of bullying in prepuberty and early youth at school and in the family. These experiences not only seriously traumatized her but also fueled her lack of trust in her parents, who had not listened to her

legitimate complaints and increased her fear of being abandoned as unworthy. There was a panicked fear of abandonment and a feeling of emptiness that Mrs. Samhir had always tried to fill with good grades at high school and university. However, deep down, none of these successes belonged to her and were only tokens to gain her parents' love and attention. The now-deceased parents had been for Mrs. Samhir, the center of a world where she had to be loved, at all costs, not only by them but by her brothers and sisters. She found her husband too cold towards her. Mrs. Samhir describes him as absolutely incapable of cuddling, and the children had also, from childhood, distanced themselves. Mrs. Samhir admits that she has always felt unloved by her parents and siblings and considered a negligible entity by her husband and children.

Mrs. Samhir's discourse expresses an almost paranoid condition from which she suffers and of which she is conscious. It is not strictly speaking a delirium because she is aware that her perception of reality is, at least partially, false, but it is a reflection. The feeling is that of an incurable lack of love, inevitable and without respite, despairing.

Considering her school memories, her insurmountable need often evoked to withdraw after social exchanges even when pleasant, for example, with her grandchildren, her difficulties with the family of origin, her divorce—wanted and decided by her—and her decisions concerning work, in a constant attempt to reduce the pressure, we proposed a targeted evaluation. We suggested that she see a psychologist to evaluate ASD and, in particular, the presence of Asperger's syndrome as well as BPD. ASD was assessed via a battery of tests developed by Baron-Cohen (Woodbury-Smith et al., 2005), and the presence of BSD was determined via the French version of the Borderline Personality Questionnaire (BPQ) (Larivière Erg, et al., 2021). The patient tested positive for BDP. We found the ASD evaluation inconclusive as there were undoubtedly features of the autism spectrum, but the overall result was a "grey area" profile without a precise diagnosis. When administering a test for Asperger's syndrome, even if some sets of questions are targeted to detect what is defined as social camouflage, specific modes of thought and action have become so automatic for the patient that they create an undetectable layer, a modus vivendi so ingrained to make assessment difficult.

Mrs. Samhir feels tired already in the morning when she gets up. The antidepressant treatment helps, of course, but does not entirely solve the problem. Anxiety is also permanent. Mrs. Samhir is afraid to abuse the anxiolysis. We prescribed her a muscle relaxant, also used in pediatrics, then an antihistamine, then pregabalin, always in low doses, but Mrs. found it all too strong, too tiring, well unnecessary.

She wants to try EMDR, then she will also try ketamine, and she would also like to try seismotherapy. We discourage her because even if it is sometimes helpful, it is not a miracle solution. What emerges is essentially a non-acceptance of the state of psychical illness.

We try to evoke with her the possibility of a developmental disorder—autism

in her case—that slows down the process of individualization by blocking the person in a phase of eternal childhood with parents-gods who, by definition, cannot have generated a sick child. We try to introduce the delicate and sensitive concept of loyalty to the parents to explain her difficulties in accepting therapy because it is seen as a betrayal of the parents-gods.

There, Mrs. Samhir rebels, finding us unprofessional, apparently unable to understand her in her difficulties, unable to give her the proper treatment, dragging on, guilty above all—this is our feeling—of not finding the "trick" to make her "normal" and worthy, finally, of her parents.

We understand that a change in a therapist is necessary, and we propose her targeted "problem-solving" therapy, which requires less digging into the psychodynamic aspect and a more structured framework.

The therapy ended on good terms, and Mrs. Samhir continued her therapeutic path by contacting a center specializing in the care of autistic disorders with a cognitive-behavioral approach.

The therapeutic approach we followed for this patient was to prescribe antidepressants and anxiolytics to ease her negative mood and constant anguish. Due to her reluctance toward anxiolytics, we prescribed a myorelaxant and pregabalin in low doses as alternatives but were unable to overcome her wariness toward these drugs. In parallel, we conducted psychodynamic-oriented psychotherapy mainly to help her elaborate on her relationship with her parents and early childhood experiences.

3. Discussion

The care of patients (especially women) with autism spectrum disorders—including Asperger's syndrome—and emotionally unstable personality disorders, such as borderline, is often seriously compromised by the lack of an early and adequate diagnosis of comorbidity. Women are particularly penalized because of social camouflage, which is more developed in them than in men. Social camouflage has the advantages of better socialization, exchange, and interaction skills. However, these are the mere effects of a mimetic hyper-adaptation, which is very constructed and even sophisticated but extremely energy-consuming, with long recovery times. Intellectual and emotional capacities focus on adaptation to others' judgment and expectations rather than one's fulfillment and development.

To clarify the path from ASD to BPD, it is necessary to consider that the autistic person encounters great difficulty in understanding the world, especially his family and the social world around him. This problem begins early because the child does not understand the reactions of parents and siblings, clashes with family members with his often-inappropriate behaviors, enters into conflict with parents, and sinks into emotional isolation. This attitude usually aggravates the misunderstanding between parents and family members, and the child experiences guilt and despair over the fact of not being like the others. We will not address here the problem of parents with autism spectrum disorders interacting with children with

the same disorder.

For the person with an autistic disorder, others, starting with parents and family members, are often incomprehensible; they make boring and useless speeches, they behave inexplicably and incoherently, and they express themselves in an ambiguous and contradictory way. To pretend to be normal, the person must learn to respond and interact in a seemingly adequate way, but this is not automatic and requires an exhausting and continuous effort. Therefore, the person tends to either have socially acceptable performances (social camouflage) paid for with enormous fatigue or to isolate.

Social camouflage is the prerogative of women (although by attentively searching under the surface, quite a few men with ASD use it extensively) and becomes a subtly invasive and energy-consuming activity. Often, patients with severe and chronic depressive states, with diagnoses of personality disorders before the discovery of Asperger's syndrome, highlight their excellent social skills, e.g., to be invited to social events because they know how to entertain the people around them and are smiling and friendly. If we stop there, we may be convinced. However, the right question is, "And after the party, how many days do you need to sleep to recover?" Almost always, this question surprises them, and they admit, not without some reluctance, to sleeping two or three days, almost continuously, hardly being able to get out of bed. However, this is done in secrecy, and practically no one realizes it. Even if they live with their families, they claim migraine, colds, and gastroenteritis, and it is difficult for the family to detect the coincidence between a social event and successive complete withdrawal.

The delay in the diagnosis of ASD leads to the adoption of therapies oriented towards a correction of symptoms and, therefore, focused on a change in the person, as if it were a neurosis, without considering the essential non-curability of a developmental disorder. This care, although offered in perfect goodwill, leads to an aggravation of the disorder, which finally takes on the characteristics of emotionally labile personality disorder of the borderline type with a worsening of anxiety, catastrophic drop in self-esteem, abandonment, impulsivity with risky behaviors and self-mutilation, often eating disorder of both types, bulimia, and anorexia.

School is also often pathogenic because the family and teachers push the child to commit to studies that far exceed their emotional capacities: regardless of whether the child is very intellectually gifted, which is often the case, the pace of studies must consider his adaptation difficulties rather than traditional academic performance. The result is a brilliant start in primary school that continues with increasing effort to higher and sometimes university studies, with changes of orientation apparently for "reasonable reasons," and often interruptions in the studies for generic health motives or following an anxious-depressive decompensation. For those who arrive to start a professional activity, it does not last more than twelve or fifteen years. Then, there is an often inexplicable loss of momentum, the emergence of conflicts with colleagues and the hierarchy, dismissal or resignation,

and finally, where offered, disability insurance due to a severe and chronic depressive, anxiodepressive or schizoaffective condition.

The school curriculum should, therefore, consider the presence of developmental disorders and reduce as much as possible the unnecessary performance-related stress, avoid a too rapid erosion of psychic energy, and give priority to the use of intellectual capacities, which are often remarkable, taking into account the difficulties of understanding the surrounding social reality.

Without completely solving the problem, this attitude would allow for more lasting emotional, intellectual, and professional adaptation and probably a longer working life with a reduced social cost. Slowing down the progression of personality disorder symptoms would be a big step in maintaining a good quality of life.

To return to care, the use of antidepressant treatment is helpful, among other things, as well as a correction of attention-deficit hyperactivity disorder (ADHD) that is often concomitant (Galli Carminati, Buttex et al., 2023a; Galli Carminati, Carminati et al., 2023b; Galli Carminati et al., 2022). From a psychotherapeutic point of view, we must consider that a developmental disorder is not curable in itself and that it is helpful to favor a self-awareness of the disorder and an adaptation between internal and external reality, concentrating on the "mourning of normality." It is also important and even necessary to support the use of one's strengths (intellectual capacity for analysis, attention to detail, ability to structure sequential tasks, ability to follow even very complex instructions) rather than trying to overcome, often without results, the weaknesses (procrastination, pathogenic perfectionism, ability to structure parallel tasks, little intuitive skill).

In the current work, we have concentrated on the ASD-BPD comorbidity in women through two clinical vignettes. The field of ASD-BPD comorbidity has received considerable attention recently for the specific therapeutic challenges it poses. Future research on ASD and BPD comorbidity should prioritize gender-specific studies, especially in men, who tend to exhibit more externalizing behaviors like aggression and substance abuse. Understanding how men camouflage ASD traits, a topic primarily studied in women, can enhance diagnostic accuracy. Neurobiological research focusing on emotional dysregulation through neuroimaging can reveal shared pathways between the two disorders.

Additionally, longitudinal studies on how ASD traits develop into BPD symptoms would help identify early intervention points. There is also a need for adapting therapies like Dialectical Behavior Therapy (DBT) for people with both ASD and BPD. Finally, exploring the effects of social stressors, trauma, and diverse cultural backgrounds will broaden the understanding of this comorbidity, leading to better treatment approaches and more personalized care.

4. Conclusion

We wanted to write this article in the hopes of helping families and caregivers understand and treat these patients. Far too often, we find ourselves confronted

with equating academic or professional performance with the mental health and well-being of the individual. When parents are asked how their child is doing, the answer is almost always "School is going well" or "he has found a job" and not, for example, "he is having fun with his friends," "he is happy with his partner" and so on. It may be the concern that the child can cater to his needs in adulthood or the reflection of our society of performance and "cut-throat" competition that we accept as normal. Moreover, when we introduce ourselves, we often give our name and profession first as a guarantee of social "legitimacy." For neurotypical individuals, all this remains a philosophical or political discussion. For individuals with comorbidities in ASD, this mixing and misunderstanding can be devastating. A late diagnosis or goodwill but clumsy efforts to treat—in the sense of "normalizing"—these patients can be dangerous, to the point of becoming an element facilitating the occurrence of other psychiatric pathologies such as the BPD described here. When confronted with these patients, we must consider the clinical aspect and consider that, for them, a particular vision of the world is both a pathology and a "way of being," which also affects the concept of healing. It is worth recalling Michel Foucault's point of view (Foucault, 2007), which argues that what society considers madness depends largely on cultural and historical contexts. We do not subscribe to the opinion that psychiatric illness is only a social construct, nor can we change society or its view of ASD carriers. Nevertheless, as caregivers, we can help our patients and their families to "create" an "ecological niche" around them that can help them live their "diversity" in the best, or at least less exhausting way possible.

5. Disclaimer

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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