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The nature of identity disruption in autistic people and people diagnosed with borderline personality disorder: A mixed-methods study

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ABSTRACT

Research shows that borderline personality disorder (BPD) is a common co-occurring diagnosis and the most frequently perceived misdiagnosis in adult-diagnosed autistic women and people assigned female at birth (women and AFAB people). One potential area of overlap between autism and BPD is identity disruption, which is closely associated with BPD and has also been linked to autistic camouflaging. This mixed-methods study compared experiences of identity disruption in autistic women and AFAB people and women and AFAB people with a BPD diagnosis. We performed a secondary mixed-methods analysis of data from self-report questionnaires and qualitative interviews.

For the quantitative analysis, we examined scores on a measure of camouflaging, scores on a measure of identity disruption and its three subscales, and correlations between them in 51 autistic women and AFAB people and 51 women and AFAB people diagnosed with BPD, all with low traits of the comparator diagnosis. Autistic participants scored significantly lower on all domains of identity disruption. Three items measuring diffused/variable identity did not differ significantly between the two groups. This domain was significantly associated with camouflaging in participants diagnosed with BPD.

We performed a deductive framework analysis of 40 interviews with 13 diagnosed autistic participants, 14 participants diagnosed with BPD, and 13 participants diagnosed with BPD who were also diagnosed with autism or suspected they were autistic. Autistic participants generally described a strong underlying sense of self despite camouflaging/contextual shifts. Lack of identity appeared to be characteristic of BPD and was related to camouflaging in autistic and possibly autistic participants diagnosed with BPD.

Our findings suggest some differences in experiences of identity disruption between autism and BPD. Camouflaging emerged as a transdiagnostic phenomenon linked to identity disruption, though it appeared more deliberate in autistic participants. Researchers and clinicians should be mindful of these areas of overlap.

Introduction

Recent years have seen increasing numbers of adults seeking an autism diagnosis, after having been missed in childhood (O'Nions et al., 2023). Many of these adults have extensive histories of contact with mental health services (Au-Yeung et al., 2019; French et al., 2023; Lai & Baron-Cohen, 2015; Shaw et al., 2022). Compared to those diagnosed as children, adult-diagnosed autistic people report a greater number of previous psychiatric diagnoses (Jadav & Bal, 2022; Kentrou et al., 2024), most likely reflecting the vulnerability of this group both to mental health challenges and to misdiagnosis of autism as other conditions (Belcher et al., 2023; McQuaid et al., 2024).

Borderline personality disorder[1] (BPD) is a common previous diagnosis and the most frequently perceived misdiagnosis in adult-diagnosed

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[1] We take a critical perspective on the diagnosis of BPD and recognise the compelling arguments made against this diagnostic construct and the severe stigma associated with this diagnosis (Klein et al., 2022; H. Porter, 2023; Shaw & Proctor, 2025; Watts, 2024). We therefore use terms such as 'people diagnosed with BPD' rather than 'people with BPD'.

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autistic people, particularly women and people assigned female at birth (henceforth women and AFAB people; Au-Yeung et al., 2019; Gesi et al., 2021; Kentrou et al., 2024), and research indicates that a significant proportion of adults diagnosed with BPD may be autistic but undiagnosed (Rydén et al., 2008; Dudas et al., 2017). Understanding the extent and nature of overlap between the diagnoses of autism and BPD may help reduce the harm caused by misdiagnosis and inappropriate treatment (Gordon et al., 2020; McQuaid et al., 2024; Parker, 2019; Watts, 2024).

The reasons for the diagnostic overlap between autism and BPD are complex. Researchers have identified a range of phenotypic similarities, such as challenges in emotion regulation and social relationships, and experiences of identity disruption, alongside the high rates of alexithymia, self-harm, and interpersonal trauma in both autistic people and people diagnosed with BPD (Cumin et al., 2022; Evans et al., 2024; Gordon et al., 2020; McQuaid et al., 2024; Sarr et al., 2025).

Identity disturbance is a core diagnostic criterion for BPD (American Psychiatric Association, 2022), characterised by an unstable, rapidly changing, or absent sense of self or personality (Kaufman et al., 2015). We use the term 'identity disruption' to acknowledge the subjective distress associated with these experiences (Jørgensen & Bøye, 2022, 2024) and the potential stigmatising connotations of the word 'disturbance'. In previous work (Barnicot et al., 2026), we found that self-reported identity disruption, as measured by the Self-Concept and Identity Measure (SCIM; Kaufman et al., 2015), represented the largest difference between autistic women and AFAB people and women and AFAB people diagnosed with BPD when the groups were compared on a large number of clinical characteristics. Further, identity disruption as per the SCIM was found to predict BPD diagnostic group membership independently of other traits measured (Barnicot et al., 2026). This finding was surprising, as research indicates that autistic people may also experience challenges related to their identity and self-concept (Evans et al., 2024; Seers & Hogg, 2023). One reason for the identified large difference between autistic participants and participants diagnosed with BPD may be that, whilst both groups experience identity disruption to some extent, the underlying mechanisms may be different.

In qualitative studies, autistic people describe experiencing identity disruption as one of the consequences of prolonged, compelled camouflaging of their autistic traits in social situations (Bargiela et al., 2016; Craddock, 2024; Hull et al., 2017; Leedham et al., 2020; McQuaid et al., 2024; Seers & Hogg, 2023). For instance, some autistic participants in Leedham et al. (2020) and Seers and Hogg (2023) perceived their camouflaging as entwined with their sense of self such that they did not know when their 'camouflaged self' began and ended. Yet, they still maintained a sense of "what might be the real me" (Seers & Hogg, 2023, p. 9), which was at odds with the 'camouflaged self' presented to others. These insights might suggest that identity disruption linked to camouflaging may not necessarily represent a loss of identity stability, but rather, challenges in reconciling one's identity with pressures to project a normative self in a predominantly non-autistic society (Petrolini & Schmidt-Boddy, 2025; Pearson & Rose, 2021).

Reinforcing the centrality of camouflaging to autistic experiences, our previous work also found a large difference between autistic people and people diagnosed with on self-reported camouflaging behaviours (Barnicot et al., 2026), as captured by the Camouflaging Autistic Traits Questionnaire (CAT-Q; Hull et al., 2019). Camouflaging predicted a high likelihood of autism diagnostic status and a low likelihood of BPD diagnostic status, independently of SCIM identity disruption scores. This indicates that, despite their interrelation in the aforementioned lived experience accounts of autistic people, identity disruption and camouflaging as measured by the SCIM and CAT-Q, respectively, likely are distinct constructs. However, some items on the SCIM appear conceptually related to camouflaging behaviours commonly seen in autistic people (Hull et al., 2017), which may reveal overlap not apparent at the scale-wide level. To illustrate, the SCIM contains several items capturing the emulation of other people, which can be interpreted as both a well-documented aspect of autistic camouflaging (Bargiela et al., 2016; Hull et al., 2019) and a characteristic of BPD-related identity diffusion (Jørgensen & Bøye, 2022).

Experiences of identity disruption associated with a BPD diagnosis have been linked to an interplay of early attachment difficulties, persistent invalidation, dissociative experiences, and emotional volatility (Kaufman & Meddaoui, 2021; Krause-Utz, 2022; Laddis et al., 2017; Steele et al., 2015). Kaufman et al. (2015) conceptualise three forms of identity disruption, which form the three subscales of the SCIM. In their framework, 'disturbed' identity refers to persistent difficulties in establishing a clear and coherent sense of identity, contradictory beliefs and values, and overreliance on others to define one's self concept. Consolidated identity entails certainty and continuity in one's sense of self and positive self-esteem, while feelings of chronic emptiness, brokenness, and identity loss correspond to lack of identity. Lived experience narratives show that identity disruption often results in a significant degree of emotional pain and distress in both autistic people and people diagnosed with BPD (Jørgensen & Bøye, 2022; Petrolini & Schmidt-Boddy, 2025), though it must also be acknowledged that the notion of 'identity disturbance' has been criticised for its lack of conceptual and clinical clarity (Hartley et al., 2022) and has been applied to unduly pathologise culturally or contextually expected experiences[2] or responses to trauma (Hartley et al., 2022; H. Porter et al., 2025).

Though researchers have attempted to conceptually compare identity disruption experiences that are more characteristic of autistic people and those with traits associated with BPD (e.g., McQuaid et al., 2024; Petrolini & Schmidt-Boddy, 2025), empirical data is lacking. Moreover, both groups report high rates of trauma, which may obscure differences in identity formation and functioning (Haruvi-Lamdan et al., 2020; Porter et al., 2020). Clarifying which aspects of identity disruption are more characteristic of autism and which may be more reflective of patterns associated with BPD can potentially help with differential diagnosis, formulation, assessment, and planning and delivering appropriate supports.

Aims and hypotheses

We aimed to characterise and compare the nature of identity disruption experienced by autistic women and AFAB people and women and AFAB people with a BPD diagnosis.

Quantitative strand

We hypothesised that:

1. Items on the *Disturbed Identity* subscale of the SCIM would be equally characteristic of autistic participants and participants diagnosed with BPD.
   a. In addition, *Disturbed Identity* items would correlate significantly with camouflaging.
2. Items on the *Consolidated Identity* and *Lack of Identity* subscales would be more characteristic of participants with a BPD diagnosis, compared to autistic participants.
   b. In addition, *Consolidated Identity* and *Lack of Identity* items would not correlate significantly with camouflaging.

No hypotheses were made regarding total score correlations between the SCIM and the CAT-Q.

[2] For instance, the highly influential paper by Wilkinson-Ryan and Westen (2000) proposed features of 'identity disturbance' such as perceived uncertainty about one's gender or sexuality that risk conferring prejudicial assumptions that may still affect research and practice (Cobbaert et al., 2026).

Qualitative strand

We aimed to complement and enrich the quantitative findings by exploring how these three forms of identity disruption, as well as camouflaging, are experienced and described in autistic women and AFAB people and women and AFAB people diagnosed with BPD, including those who suspected they were autistic or were diagnosed with autism.

Methods

Study design

This study represents a convergent mixed methods (Creswell & Cresswell, 2022) secondary analysis in two separate samples of previously collected quantitative and qualitative data, characterising how women and people assigned female at birth (women and AFAB people) who are autistic and/or are diagnosed with BPD may experience identity disruption. The quantitative strand examined item- and subscale-level differences on the SCIM between autistic participants and participants diagnosed with BPD (with low traits of the comparator diagnosis), as well as correlations between the subscales of the SCIM and the CAT-Q, to understand experiences and relationships that may be more characteristic of each diagnosis. The qualitative strand complemented and enhanced the quantitative strand by examining in a separate sample how the concepts of interest (the three domains of identity disruption, as per the SCIM, and camouflaging) may be expressed by autistic women and AFAB people, and women and AFAB people diagnosed with BPD, including those who are diagnosed with autism or self-identify as autistic (Greene et al., 1989), thereby allowing for a deeper, more nuanced understanding of experiences of identity disruption in these groups that would be gained from the quantitative data alone (Creswell & Cresswell, 2022; Plano Clark & Ivankova, 2016).

Ethical approval

All data was collected as part of a wider study comparing the clinical presentation and lived experience of autistic adults and adults diagnosed with BPD (https://www.autismandpersonalitydisorder.org), approved by the West Midlands-South Birmingham NHS Research Ethics Committee on 14 January 2022 (REC 21/WM/0287, IRAS 307912). All participants provided informed consent prior to participation. No separate approval was needed for the present secondary analysis.

Inclusion and exclusion criteria

The inclusion and exclusion criteria for both strands of the present analysis are summarised in Table 1. Both samples were restricted to women (cisgender and transgender) and AFAB people. This choice was made due to evidence suggesting that cisgender women, AFAB people, and gender-diverse adults tend to be diagnosed with autism later than cisgender men and following a greater number of psychiatric diagnoses, including personality disorders (Abu-Ramadan et al., 2025; Kentrou et al., 2024; McQuaid et al., 2024; Zidane Burgess et al., 2026), which renders issues of differential diagnosis particularly relevant to these groups.

Participants who self-identified as autistic, or suspected they were autistic, were eligible for inclusion in the qualitative study on par with clinically diagnosed participants, in line with other qualitative studies on the experiences of autistic adults (Ardeleanu et al., 2024; Cohen et al., 2022; Tien et al., 2025). This choice was made in light of substantial evidence indicating enduring barriers to accessing diagnosis for women and AFAB people (Abu-Ramadan et al., 2025; Lockwood Estrin et al., 2021), which are frequently compounded for women and AFAB people diagnosed with BPD (McQuaid et al., 2024; Tamilson et al., 2025). Self-identifying autistic adults tend to exhibit comparable levels of autistic characteristics to formally diagnosed individuals (Sturm et al., 2024), and the majority of adults seeking an autism assessment in the UK do go on to receive an autism diagnosis (e.g., Robinson et al., 2025).

Table 1
Study inclusion and exclusion criteria.

Inclusion	Exclusion
Quantitative Study	
Age ≥ 18 years	Diagnosed with schizophrenia spectrum disorder
Assigned female at birth or transgender women	Moderate or severe learning disability
Resident in the UK	Living outside of the UK
Autism Group	
Current autism diagnosis	
Never diagnosed with any personality disorder	
Score < 7 on the MSI-BPD[a]	
BPD Group	
Current BPD diagnosis	
Not diagnosed with autism or suspected to be autistic	
Score ≥ 4 on the MSI-BPD[b]	
Score < 23 on the RAADS-14[c] and/or < 6 on the AQ-10[d]	
Qualitative Study	
Age 18–65 years	Diagnosed with schizophrenia spectrum disorder
Assigned female at birth, or transgender women predominantly socialised as female	Moderate or severe learning disability or lacking capacity to provide consent
Resident in the UK	Living outside of the UK
Autism Group	
Diagnosed or self-identifying as autistic	
Never diagnosed with any personality disorder	
Personality Disorder Group	
Current personality disorder diagnosis[e]	
Not diagnosed with autism or suspected to be autistic	
Autism + Personality Disorder Group	
Current personality disorder diagnosis	
Diagnosed or self-identifying as autistic	

[a] A cutoff score of 7 provides optimal sensitivity and specificity for distinguishing those who meet and do not meet criteria for BPD in psychiatric samples (Zanarini et al., 2003).
[b] A cutoff score of 4 provides *maximum* sensitivity (0.98) for identifying those who meet criteria for BPD (Zanarini et al., 2003).
[c] A cutoff of 23 provides optimal sensitivity and specificity among psychiatric patients (Eriksson et al., 2013).
[d] A cutoff score of 6 is generally recommended for identifying clinically significant autistic traits (Allison et al., 2012).
[e] While participants with any personality disorder diagnosis were eligible to participate, all but one participant (excluded from this secondary analysis) had a BPD diagnosis.

Recruitment

The qualitative study was open to recruitment between February and November 2022, while data collection for the quantitative study took place between January and July 2023. Both studies were advertised to clinicians and Research and Development teams at participating NHS Trusts in three regions of England (North West, Midlands, and South East), who referred potentially eligible participants. Recruitment was supplemented with waiting room flyers, social media, and networks including the National Institute for Health and Care Research's Be Part of Research network and the Scottish Women's Autistic Network.

For each study, potential participants reviewed the participant information sheet and provided informed consent, followed by completing screening questionnaires to assess eligibility for the respective study. Participation in the qualitative study was not an exclusion criterion for the quantitative study.

Quantitative study

Data collection

The study was hosted on Qualtrics (https://www.qualtrics.com). Eligible participants completed the full set of study measures on Qualtrics online or alternatively by email, post, or video call. We aimed to recruit 51 participants per group, allowing us to detect between-group differences of Cohen's $d = 0.6$ with 85% power at alpha = 0.05. Participants were compensated with a £ 25 voucher for their time. The original study included a series of validated measures representing areas of potential overlap between autism and BPD (e.g., emotional regulation, rejection sensitivity, social and sensory processing, and identity difficulties; see Barnicot et al., 2026 for the full list of measures). For the present analysis, we only examined scores on the SCIM and the CAT-Q. Incomplete responses, or responses with any missing measures, were removed prior to analysis ($n = 38$).

The SCIM contains 27 items assessing identity functioning and disruption and consists of three subscales: *Disturbed Identity*, *Consolidated Identity*, and *Lack of Identity*. The SCIM has shown good measurement properties in clinical (Kaufman et al., 2019) and community samples (Kaufman et al., 2015) (α_{whole} =.93, α_{autism} =.90, α_{BPD} =.89).

The CAT-Q contains 27 items assessing engagement in strategies aimed at reducing the perception of autistic traits in social situations, and has been validated for both autistic (Hull et al., 2019) and non-autistic samples (Ai et al., 2024) (α_{whole} =.94, α_{autism} =.91, α_{BPD} =.94). The CAT-Q consists of three subscales capturing separate facets of camouflaging, though subscale-level analysis of the CAT-Q was outside of the scope of this study.

Analysis

We conducted a subscale and item-level analysis of the three subscales of the SCIM to determine which items differentiated between autistic participants and participants diagnosed with BPD. We performed *t*-tests and computed Cohen's *d* for all SCIM items and subscales. We used a Benjamini-Hochberg correction across all 27 per-item comparisons and reported the raw and adjusted *p*-values, using the threshold of adjusted $p < .05$ for significance.

In addition, to determine whether any of the SCIM domains were correlated with the camouflaging of autistic traits, we computed Pearson's correlations between each subscale and the CAT-Q in both diagnostic groups and the whole sample, applying a Benjamini-Hochberg correction across all comparisons (given that separate hypotheses had not been made regarding the autism and BPD groups) and using a significance threshold of adjusted $p < .05$. Shapiro-Wilks tests indicated that all subscale scores fit a normal distribution, so no data transformations were performed. An inspection of scatterplots of pairwise relationships revealed no evident deviations from linearity, as reported in the Supplement. A sensitivity analysis using Spearman's correlations was further conducted, which can also be found in the Supplement.

Qualitative Study

Data collection

We used two sources of qualitative data: semi-structured interviews and the Structured Clinical Interview for DSM-5 Personality Disorders (SCID; First et al., 2015) conducted as part of the larger-scale study. The semi-structured interview topic guide covered areas of potential convergence and divergence across autistic people and people diagnosed with BPD: describing one's personality; perceived influences on personality development; relationships, social interactions, and emotions; and subjective experiences of cognitive functioning and processing. The SCID is a structured diagnostic interview used to assess for traits associated with personality disorders, including BPD, and has shown excellent psychometric properties in clinical and research settings (First et al., 2015). We used participants' responses to SCID questions 4c ('Have you all of a sudden changed your sense of who you are and where you are headed?'), 4d ('Does your sense of who you are often change dramatically?'), 4e ('Are you different with different people or in different situations, so that people don't know who you really are?'), and 4 f ('Have there been lots of sudden changes in your goals, career plans, religious beliefs etc.?') for this analysis. The qualitative interviews and the SCID were administered during separate study visits over videoconference, by telephone, or face-to-face, with comfort breaks provided as needed, and transcribed verbatim.

Whilst this was a secondary analysis of previously collected interview data and no participants were recruited specifically for this study, we appraised sampling adequacy using the notion of *information power*. The concept of information power posits that the more relevant information the sample holds, the fewer participants are needed (Malterud et al., 2016). The present qualitative analysis had a relatively narrow aim and relied on established thematic categories. The available sample was also relatively specific given the aims of the original study and the present study, and the interviews contained rich and detailed narratives of participants' experiences of identity and camouflaging. Although cross-group comparisons would presumably necessitate comparatively larger samples, the size of each of our qualitative groups was broadly in line with the sample sizes used in other qualitative studies on experiences of identity in autistic people (e.g., Cohen et al., 2022; Mesa & Hamilton, 2022; Øverland et al., 2026).

Analysis

We used framework analysis (Gale et al., 2013; Goldsmith, 2021) to analyse how participants experienced identity disruption and social camouflaging in the context of identity. We chose a deductive method in order to support integration with the quantitative strand and constructed a four-theme analytical coding framework based on the three SCIM domains and the three subscales of the CAT-Q (Table 2).

We undertook the following steps, in line with Gale et al. (2013):

1. The lead researcher read all interview and SCID transcripts and noted initial interpretations.
2. The coding framework was applied systematically to relevant segments of all transcripts; codes were refined, added, and expanded as needed to capture emerging patterns within each of the four themes.
3. Indexed data from each diagnostic group (autism only, BPD only, [diagnosed or suspected] autism + BPD), was charted into a framework matrix. Initial notes were made.
4. During the writeup stage, patterns from the data were interpreted and compared across groups. Cases appearing discrepant, disconfirming, or contradictory to predominant patterns were carefully examined and incorporated to refine and enrich our interpretations of the four concepts (Fife & Gossner, 2024; Sale & Carlin, 2025).

Reflexivity

The study team comprised academic researchers, alongside clinical academics and researchers with lived experience from multidisciplinary backgrounds including psychology and mental health nursing. We adopt a neurodiversity-affirming approach in relation to autism (Dwyer et al., 2025) and appreciate critical viewpoints on the construct of BPD (e.g., Watts, 2024). The larger-scale study was co-designed and co-led by an autistic researcher with lived experience of a BPD diagnosis. This was supported through regular oversight from a lived experience advisory group and a clinician advisory group to ensure findings were aligned to the data. The coding for this secondary analysis was conducted by the first author who does not have lived experience. All interpretations for the present analysis were reviewed extensively by the lived experience co-researcher. The remaining members of the research team provided regular feedback and reviewed data excerpts to ensure interpretative decisions were supported by the data and aim to mitigate researcher

Table 2
Qualitative deductive coding framework.

Theme	Codes	Illustrative Quotes
1. 'Disturbed'/ Situational Identity	1.1 Deriving one's sense of self through others. 1.2 Values, interests, and beliefs changing rapidly. 1.3 Contradictory traits. 1.4 Changing significantly between situations/ contexts. 1.5 Not knowing one's beliefs. 1.6 Feeling 'enmeshed' with other people.	1.1 "It depends on who I'm with" (P514, diagnosed with both) 1.2 "I feel like right now they change quite a lot" (P307, diagnosed with BPD" 1.3 "there is two contradictions in that I really like people… And yet on the other hand I am quite sort of fearful and find it very, very difficult to feel safe around people" (P107, diagnosed autistic) 1.4 "I don't know who to go as or who to be" (P530, diagnosed autistic) 1.5 "What I like and what I don't like is actually very hard for me to understand" (P112, diagnosed autistic) 1.6 "Feeling like I'm just like this… empathy vessel that I'm just there to help people feel better and help people work through their feelings" (P120, diagnosed with BPD)
2. Consolidated Identity	2.1 Having a strong sense of one's values and beliefs. 2.2 Knowing who one 'truly' is. 2.3 Continuity between past and present. 2.4 Positive self-image.	2.1 "No matter how good someone's argument is like, they won't be able to persuade me" (P507, diagnosed with BPD, possibly autistic) 2.2 "I would say I'm relatively authentic as to who I am" (P120, diagnosed autistic) 2.3 "Learning to become more aware of what might be going on… I suppose, that's why I said it influenced my personality" (P540, diagnosed autistic). 2.4 "I try to be quite caring" (P518, diagnosed with BPD, possibly autistic)
3. Lack of Identity	3.1 Painful feelings of emptiness. 3.2 Feeling 'broken' or fragmented. 3.3 Not knowing who one is.	3.1 "Just a sense of feeling lost? Like not really being able to understand who I am" (P405, diagnosed with BPD) 3.2 "I've been described as glass before, like fragile" (P303, diagnosed with BPD) 3.3 "I don't really know if I have like a sort of solid state" (P401, diagnosed with BPD, suspects autistic)
4. Camouflaging[a]	4.1 Imitating and mimicking others in social situations *to match social expectations* 4.2 Workarounds for perceived social difficulties. 4.3 Hiding aspects of oneself in social situations.	4.1 "As long as I can pick up what the kind of tone is then [I can] kind of almost like mimic" (P120, diagnosed with BPD) 4.2 "I've probably learned to find ways to [ask questions] a little bit less directly" (P540, diagnosed autistic) 4.3 "I'm much louder at home. I do a lot of masking. I'm quiet, I feel like I am holding a lot in" (P514, diagnosed with both)

b When participants narratively linked camouflaging to experiences of identity disruption, this was dually coded both under camouflaging and the appropriate identity code.

[a] To avoid the potentially pathologising connotations of the word 'disturbed', this domain is referred to as 'Disturbed'/Situational Identity.

bias. Any disagreements or divergent interpretations were discussed collaboratively until consensus was reached.

Data Integration

Upon the completion of both analyses, the quantitative and qualitative findings were integrated to identify and understand areas of convergence and divergence in the experiences of identity disruption across diagnostic groups (Creswell et al., 2003). This integration was presented in the form of a joint display, presenting the two sets of findings side-by-side to facilitate comparison (Guetterman et al., 2015), along with meta-inferences concerning the extent of the 'fit' between the two sets of findings and potential interpretations of this fit (Fetters, 2020). Given the limited overlap between the quantitative and qualitative samples, data integration occurred at the construct level, rather than at the individual participant level. Therefore, the three forms of identity disruption under examination in this study, as well as camouflaging, were used as units of integration.

Results

Quantitative analysis

Sample

The key characteristics of the quantitative sample are provided in Table 3.

Item-level differences between groups

Table 4 summarises the average scores on each item of the SCIM in both groups, the Cohen's *d* for the standardised mean difference, and the raw and adjusted *p*-values following a Benjamini-Hochberg correction for a false discovery rate (FDR) of .05.

Total scores on each subscale of the SCIM were significantly higher in participants diagnosed with BPD, compared to autistic participants (all adjusted p's $< .001$). An item-level analysis showed that three of the 11 items on the *Disturbed Identity* subscale did not differ significantly between autistic participants and participants diagnosed with BPD. The

Table 3
Participant characteristics (quantitative study).

	Autistic participants ($n = 51$)	Participants meeting criteria for BPD ($n = 51$)
Sex at birth	49 (96%)	50 (98%)
Female	2 (4%)	1 (2%)
Male		
Gender identity	37 (72%)	48 (94%)
Cisgender woman	14 (28%)	3 (6%)
Gender diverse[a]		
Mean age (SD)	34.6 (10.0)	34.8 (12.7)
Ethnicity	44 (86%)	49 (96%)
White (British/other)	7 (14%)	2 (4%)
Black and minority ethnic		
Mean AQ-10 score (SD)	8.0 (1.6)	3.7 (2.2)
Mean MSI-BPD score (SD)	3.8 (2.0)	8.2 (1.6)
Mean CAT-Q score (SD)	5.0 (0.9)	3.9 (1.2)
Parent/caregiver emotional abuse	12 (24%)[b]	34 (68%)[c]
Parent/caregiver physical abuse	8 (17%)[d]	23 (46%)[c]
Childhood sexual assault	13 (27%)[b]	28 (56%)[c]
Bullying	24 (49%)[b]	16 (32%)[c]

[a] Includes transgender woman, non-binary, agender, gender fluid, rejects gender as a construct; [b] $n = 49$; [c] $n = 50$; [d] $n = 48$. AQ-10: The Short Autism Spectrum Quotient (Allison et al., 2012). MSI-BPD: McLean Screening Instrument for Borderline Personality Disorder (Zanarini et al., 2003). CAT-Q: Camouflaging Autistic Traits Questionnaire (Hull et al., 2019).

Table 4
An item-level analysis of the SCIM.

SCIM Item	Autism Mean (SD), $n = 51$	BPD Mean (SD), $n = 51$	Cohen's *d*, 95% CI	*t*-value	Raw *p*-value	FDR Adjusted *p*-value
Total	80.2 (22.4)	110.7 (22.7)	1.36 [0.92, 1.79]	6.85	.000	.000
Disturbed Identity Subscale Total	32.7 (10.6)	42.6 (11.2)	0.91 [0.50, 1.31]	4.59	.000	.000
4	3.3 (1.8)	3.6 (1.8)	0.15 [-0.24, 0.55]	0.78	.440	.440
6	4.7 (1.6)	5.4 (1.2)	0.50 [0.11, 0.90]	2.55	.013	.016
8	2.3 (1.5)	3.5 (1.7)	0.75 [0.34, 1.16]	3.78	.000	.001
12	3.5 (1.7)	4.0 (1.8)	0.34 [-0.06, 0.73]	1.69	.094	.101
15	3.6 (2.0)	4.6 (1.7)	0.56 [0.16, 0.96]	2.82	.006	.009
21	2.6 (1.8)	3.0 (1.8)	0.23 [-0.17, 0.67]	1.14	.258	.267
24	2.6 (1.6)	4.4 (1.6)	1.13 [0.70, 1.55]	5.68	.000	.000
26	3.1 (1.6)	3.9 (1.8)	0.42 [0.02, 0.81]	2.09	.039	.043
28	2.8 (1.6)	3.7 (1.7)	0.53 [0.13, 0.93]	2.67	.009	.013
29	1.9 (1.1)	3.8 (1.7)	0.86 [0.45, 1.27]	4.34	.000	.000
30	2.2 (1.4)	3.2 (1.6)	0.67 [0.26, 1.07]	3.36	.001	.002
Consolidated Identity Subscale Total	29.6 (7.3)	40.6 (9.5)	1.29 [0.86, 1.72]	6.54	.000	.000
1	1.8 (0.8)	2.8 (1.5)	0.83 [0.42, 1.23]	4.17	.000	.000
2	3.2 (1.4)	3.9 (1.6)	0.47 [0.07, 0.87]	2.37	.020	.024
3	3.7 (1.9)	4.5 (1.9)	0.43 [0.27, 0.82]	2.15	.034	.040
5	2.8 (1.4)	4.4 (1.7)	1.05 [0.63, 1.37]	5.30	.000	.000
11	2.9 (1.0)	4.2 (1.6)	0.95 [0.53, 1.36]	4.79	.000	.000
14	2.2 (1.1)	3.7 (1.7)	1.05 [0.63, 1.47]	5.31	.000	.000
17	4.0 (1.9)	5.3 (1.7)	0.69 [0.28, 1.09]	3.46	.001	.001
19	2.4 (1.5)	3.3 (1.7)	0.53 [0.13, 0.93]	2.66	.009	.013
20	2.3 (1.0)	3.3 (1.4)	0.84 [0.43, 1.25]	4.24	.000	.000
22	4.4 (2.0)	5.3 (1.6)	0.51 [0.11, 0.91]	2.56	.012	.016
Lack of Identity Subscale Total	17.9 (7.6)	27.6 (7.7)	1.27 [0.84, 1.69]	6.40	.000	.000
10	3.6 (1.8)	4.6 (1.8)	0.54 [0.14, 0.94]	2.70	.008	.012
16	3.6 (1.6)	5.5 (1.4)	1.24 [0.85, 1.72]	6.49	.000	.000
18	3.3 (1.7)	5.0 (1.5)	1.08 [0.66, 1.50]	5.45	.000	.000
23	2.3 (1.6)	4.3 (1.7)	1.17 [0.75, 1.60]	5.93	.000	.000
25	2.0 (1.3)	3.8 (1.8)	1.12 [0.70, 1.54]	5.66	.000	.000
27	3.0 (1.8)	4.4 (1.7)	0.79 [0.38, 1.20]	3.99	.000	.000

three items that did not differ between the two groups were Items 4 ('Sometimes I pick another person and try to be just like them, even when I'm alone'), 12 ('I imitate other people instead of being myself'), and 21 ('I am so similar to certain people that sometimes I feel like we are the same person'). As predicted, participants diagnosed with BPD scored significantly higher on all items on *Consolidated Identity* and *Lack of Identity* (all adjusted *p*'s $< .05$).

Relationships with camouflaging

Autistic participants scored significantly higher on the CAT-Q than participants diagnosed with BPD ($M_{Autism} = 124.2$, $SD_{Autism} = 21.4$, $M_{BPD} = 98.3$, $SD_{BPD} = 29.2$, $t(91.76) = 5.11$, $p < .001$, Cohen's $d = 1.01$, 95% CI [0.60, 1.42]). The results of an analysis of correlations between CAT-Q scores and the three SCIM subscales are presented in Table 5.

Following a Benjamini-Hochberg correction across all twelve correlations tested, the only relationship remaining significant was the positive correlation between the CAT-Q and the *Disturbed Identity* subscale

Table 5
Correlations between the CAT-Q and the SCIM.

	Pearson's *r*, 95% CI	Raw *p*-value	FDR Adjusted *p*-value
SCIM Total			
Whole sample	-.02 [-.21,.18]	.873	.873
Autism	.31 [.03,.54]	.029	.075
BPD	.35 [.08,.57]	.011	.068
SCIM Disturbed Identity			
Whole sample	.10 [-.10,.29]	.312	.375
Autism	.30 [.03,.53]	.031	.075
BPD	.40 [.14,.61]	.003	.039
SCIM Consolidated Identity			
Whole sample	-.13 [-.32,.06]	.180	.308
Autism	.17 [-.11,.43]	.226	.338
BPD	.14 [-.13,.40]	.312	.375
SCIM Lack of Identity			
Whole sample	-.03 [-.23,.16]	.747	.815
Autism	.31 [.04,.54]	.026	.075
BPD	.27 [-.01,.51]	.055	.110

in the BPD group ($r(49) = .40$, 95% CI [.14,.61], $p_{adj} = .039$). A Spearman's sensitivity analysis, reported in the Supplement, did not change the pattern of significance, and all Spearman's correlation coefficients were within .06 of the respective Pearson's correlation coefficients.

Qualitative analysis

Sample

In total, 40 interviews were used for the present analysis. The original study included an interview with an additional participant diagnosed with another personality disorder, whose interview is excluded from this analysis due to our focus on autism and BPD. The qualitative sample includes five participants (three autistic, two BPD only) who also took part in the quantitative strand. Table 6 summarises the demographic characteristics of the qualitative sample.

Table 6
Participant characteristics (qualitative study).

	Autistic participants without a BPD diagnosis[a] ($n = 13$)	Non-autistic participants diagnosed with BPD[b] ($n = 14$)	Autistic and possibly autistic participants diagnosed with BPD[c] ($n = 13$)
Gender identity	11 (84.6%)	12 (85.7%)	10 (76.9%)
Cisgender female	2 (15.4%)	2 (14.2%)	3 (23.1%)
Gender diverse[d]			
Age	-	2 (14.2%)	3 (23.1%)
18–24	3 (23.1%)	10 (67%)	6 (46.2%)
25–34	4 (30.8%)	-	3 (23.1%)
35–44	5 (38.5%)	-	-
45–54	1 (7.7%)	-	-
55 +	-	2 (14.2%)	4 (30.8%)
Unknown			
Ethnicity	12 (92.3%)	13 (92.9%)	12 (92.3%)
White	-	1 (7.1%)	1 (7.7%)
(British/ other)	1 (7.7%)	-	-
Asian			
Prefer not to say			
AQ-10 score (SD)	7.5 (1.9)	4.9 (1.9)	6.6 (2.7)
PAQ score (SD)	35.5 (5.6)	41.3 (7.8)	43.5 (6.3)
SAPAS score	4.7 (1.7)	4.4 (1.4)	5.0 (1.7)
Questioning BPD diagnosis	-	10 (71.4%)	10 (76.9%)
Above threshold on ITQ	2[e] (16.7%)	5 [f] (45.5%)	5[e] (41.7%)
Parent/ caregiver emotional abuse	3 (23.1%)	3 (21.4%)	4 (30.8%)
Parent/ caregiver physical abuse	1 (7.7%)	3 (21.4%)	1 (7.7%)
Childhood sexual assault	4 (30.8%)	6 (42.8%)	6 (46.2%)
Bullying	5 (38.5%)	4 (28.4%)	1 (7.7%)

[a] All had been diagnosed with autism.
[b] Includes emotionally unstable personality disorder.
[c] Includes three diagnosed and ten self-identified/suspected.
[d] Includes nonbinary, genderqueer, and agender participants.
[e] $n = 12$.
[f] $n = 11$. AQ-10: The Short Autism Spectrum Quotient (Allison et al., 2012). PAQ: Personality Assessment Questionnaire for ICD-11 (Kim et al., 2021). SAPAS: Standardised Assessment of Personality - Abbreviated Scale (Moran et al., 2003). ITQ: International Trauma Questionnaire (Cloitre et al., 2018).

The themes below are illustrated with quotes from participants, labelled to indicate their identification/diagnosis with autism, BPD, or both.

'Disturbed'/situational identity

Some participants across both diagnoses reported a fluid, context-dependent sense of identity, described as "*feeling like a completely different person depending on the [social] environment*" (P405, diagnosed with BPD) or "*on who I'm with… on the time of the month…it depends on so much*" (P111, diagnosed autistic). These shifts in the way participants saw themselves often depended on other people's presence and the relationships they had with them: "*it changes depending on who I'm around and what they're like, really*" (P517, diagnosed with BPD, suspects is autistic); "*I can almost be too swayed by what other people say… if it's someone I respect, I might flop more significantly in that direction*" (P550, diagnosed autistic).

A key difference between the groups, however, was that autistic participants seemed to be more likely to maintain a core identity, and participants diagnosed with BPD experienced more fluctuating identities. For instance, while participants across diagnostic groups sometimes experienced changeable interests or values as part of their identity: "*They change a lot*" (P307, diagnosed with BPD); "*It is not fixed at all*" (P531, diagnosed autistic), some, though not all, autistic participants were more likely to maintain an underlying sense of their values and interests: "*What I'm focusing on changes, but not like my broad attitude towards the thing*" (P550, diagnosed autistic). However, maintaining them around others appeared more challenging for those with a BPD diagnosis: "*What's harder for me is to hold onto my likes and dislikes around other people*" (P401, diagnosed with BPD, suspects is autistic).

Further, descriptions of seemingly contradictory and changing traits and tendencies were particularly characteristic of participants with a BPD diagnosis, regardless of whether or not they were diagnosed with autism or suspected they were autistic: "*I alternate between bubbly, social, depressive, and loner*" (P503, diagnosed with BPD but questioning); "*I'm very much an introvert but like really extroverted with the right people*" (P513, diagnosed with BPD, suspects is autistic). Some appeared to easily reconcile these contradictions: "*I think I need both [spending time on my own or with others] in equal measures*" (P100, diagnosed with BPD but questioning, suspects is autistic), while others expressed a degree of tension between them: "*I can be spontaneous and impulsive – let's do things last minute. Also I need routine! It contradicts*" (P514, diagnosed with both). Autistic participants without a BPD diagnosis, on the other hand, did not appear to report such experiences in the interviews.

Consolidated identity

Co-existing with the aforementioned experiences of variable and shifting observable behaviour, many participants across diagnostic groups were "*adamant about [their] moral and political beliefs*" (P403, diagnosed autistic) and held "*strict morals, thoughts, and opinions on what's right and what's wrong*" (P120, diagnosed with BPD). Many derived a positive self-concept through their values and beliefs, such as "*helping people, making a difference, seeing things get better*" (P111, diagnosed autistic) or "*seeking out love and wanting to give love*" (P120, diagnosed with BPD).

Most autistic participants were able to clearly describe how they viewed themselves, despite outward changes in behaviour (see 'Disturbed'/Situational Identity for examples of identity contradictions): "*I'm just quite like upfront and honest and expect the same from other people*" (P550, diagnosed autistic). In contrast, expressing a consolidated identity appeared more tentative in those with a BPD diagnosis without suspected autism, e.g., "*I can be like prone to being irritable, being impulsive, and being a bit irresponsible sometimes*" (P120). However, some participants in this group expressed a clear, consolidated identity at odds with conceptualisations of BPD as "*wishy washy and not really like*

knowing who you are… that's never rang true for me. I know exactly who I am" (P305).

Stable, consistent self-concepts across both groups often included an awareness of their flaws and how they appeared over time, thus suggesting continuity and self-reflection: "*I'm sometimes a little bit over the top… can be quite snappy… impatient*" (P540, diagnosed autistic). While participants were often able to notice and reconcile these changes, alexithymia traits appeared to hinder self-understanding and identity consolidation for some autistic, or potentially autistic, participants: "*Equally, I could also not understand my own reaction to something*" (P540, diagnosed autistic). Some have developed an awareness in reconciling their identities after periods of adversity or disruption: "*But now I kind of know who I am. I've learned over the years who I am*" (P100, diagnosed with BPD, suspects is autistic).

Across diagnostic groups, past adversity served to aid identity consolidation at times, despite introducing and reinforcing challenges with camouflaging and identity diffusion. Some demonstrated a sense of continuity, allowing them to understand how their past affected their present: "*I have experienced significant trauma in childhood and that has… made me probably a lot more introverted than I would otherwise have been and also have more difficulties in stuff like emotional regulation and anxiety*" (P550, diagnosed autistic). Reflecting on the past has also enabled identity continuity in the form of self-reflection, self-compassion, and the ability to note positive changes over time: "*I used to be more social as a teenager … tried really hard to just fit in with everyone … but now I'm just trying to look after myself" (*P303, diagnosed with BPD); "*In the past [the reason] I got so depressed was because I didn't acknowledge [that] I tended to push away and ignore what was going on… I've learned to pay attention to that*" (P540, diagnosed autistic).

One autistic participant described experiencing identity continuity through self-reflection, which they linked to their autistic characteristics: "*I think one of the reasons why I've internalised and obsessed over [past trauma] and I still do it is because I genuinely am on the spectrum*" (P403, diagnosed autistic). Receiving an autism diagnosis also seemed to aid identity consolidation by helping form a more coherent, positive sense of self, validating past identity experiences, and removing self-blame for being 'different': "*Oh, maybe it's not that I am not trying hard enough, maybe I do actually like experience the world in a completely different way to other people" (*P536, diagnosed autistic). Interestingly, the positive effects of diagnosis were not discussed in relation to BPD in the interviews, and a large proportion questioned their diagnosis.

Overall, autistic participants were more likely to express a stable, consolidated sense of self compared to some participants diagnosed with BPD who were, generally, more hedged and tentative when discussing their sense of identity. However, alexithymia traits appeared to complicate identity consolidation for some autistic participants, and some participants diagnosed with BPD described coherent, stable identities.

Lack of identity

Some participants, notably those with a BPD diagnosis, reported lacking a sense of identity. This was described as "*not really being able to understand who I am*" (P405, diagnosed with BPD) or simply not "*[knowing] who I am*" (P513, diagnosed with BPD, suspects is autistic). At times, experiences of lack of identity were attributed to prolonged camouflaging or interpersonal trauma: "*Whether it's good or bad, it's always other people. There's never really been anything that's been my own influence*." (P513, diagnosed with BPD, suspects is autistic). The sense of lack of identity extended even to supposedly safe social spaces, therefore highlighting its pervasiveness: "*I still don't really know who I am. I never know if I'm just channelling [my friends'] energy or if I'm actually being myself*" (P513, diagnosed with BPD, suspects is autistic). Even if participants had a relatively strong sense of their values, a core sense of identity was sometimes absent: "*I know the things that matter to me and I know some of the things that I like, but I wouldn't know how to define who I am really*" (P507, diagnosed with BPD, suspects is autistic).

The associated emotional states for participants diagnosed with BPD were described as "*lost, like not really being able to understand who I am*" (P405, diagnosed with BPD); "*[like] glass… fragile, which I think is actually very appropriate*" (P303, diagnosed with BPD). As a result of these emotions, some felt alienated from others, as in "*no-one wants to be around me basically*" (P303, diagnosed with BPD), or a sense of illegitimacy or inadequacy "*I shouldn't be in the position that I am in. Like, I am not like mature enough almost… I am just not equipped*" (P303, diagnosed with BPD).

Across available transcripts from autistic participants without a BPD diagnosis, we found little evidence of similar experiences of lack of identity. However, in some cases, traumatic circumstances shattered their sense of identity, resulting in temporary disruption: "*Before I had a long period of depression, I saw myself as very competent, and very together, and very no-nonsense. That was a bit of an identity crisis, because I'm not who I thought I was*" (P540, diagnosed autistic).

In sum, lack of identity and associated distress were primarily experienced by some participants diagnosed with BPD (regardless of diagnosed/suspected autism) rather than by autistic participants without a BPD diagnosis, except for temporary experiences of disruption linked to external factors.

Camouflaging

Across diagnostic groups, camouflaging appeared connected to identity disruption, but it appeared to have different functions in autistic participants and participants diagnosed with BPD. Autistic participants, in particular, were conscious of being compelled to deliberately change their behaviour to fit in certain social contexts: "*I present my personality differently in different spaces… I have a work [name], and I have a home [name], and I have a going out to a gig [name]*" (P536, diagnosed autistic); "*I don't want people to think that I'm rude and unpleasant. I suppose I just try and put energy into that if I have to*" (P110, diagnosed autistic). They described camouflaging as sometimes resulting in feelings of fragmentation and identity confusion: "*I'm so often a different kind of person that I kind of end up losing sense of my own personhood*" (P403, diagnosed autistic). Nonetheless, autistic participants seemed to distinguish between what they perceived as their camouflaged and authentic selves, despite contextually changing appearances: "*I always have a certain amount of consistency*" (P107, diagnosed autistic).

In contrast, some participants diagnosed with BPD seemed to be affected by their environments in a less deliberate way, resulting in overt changes to their behaviour: "*The context can make me quite a different person… There's a lot of situations where [the changeability] is much more pronounced for me*" (P100, diagnosed with BPD but questioning, suspects is autistic). At times, the shifting sense of self served to avoid rejection: "*I'll kind of mould myself to the people that I'm with to avoid them rejecting me*" (P120, diagnosed with BPD). Interestingly, participants diagnosed with BPD who were diagnosed with autism or suspected they were autistic appeared to feel some degree of inauthenticity or incongruence, whilst simultaneously struggling to understand who they were: "*I always feel like I'm like hiding or whatever… but I also don't really know what it means to be myself, like I'm not sure so… I know that I find it difficult.*" (P518, diagnosed with BPD, possibly autistic).

One participant noted that perceived changeability in their behaviour may have contributed to their BPD diagnosis, although they felt it was not fully appropriate: "*[Clinicians] don't necessarily understand the context very well… They'll say, 'Your mood changes hour to hour'. No, it changes when something happens,*" (P503, diagnosed with BPD but questioning).

Finally, early negative experiences pressured participants to camouflage aspects of themselves with enduring consequences: "*My dad was a bit like, 'You need to act like a bit more feminine'… and then I think by Year 5, Year 6, I kind of like was a lot quieter.*" (P404, diagnosed with BPD); "*I tried really hard to be like them. And I'd copy something really meticulously just how they were doing it, but when I did it…. they all laughed at me for*

doing it… it was right for you to do it but I wasn't allowed to do it" (P111, diagnosed autistic). At times, participants rejected social models that did not align with their desired identity: "*Once upon a time I modelled myself on somebody really laid back… because I just didn't want to be rigid and inflexible like my mum actually*" (P111, diagnosed autistic).

While both groups reported variable, often context-dependent sense of identity, autistic participants seemed to retain a core sense of identity and values, even when camouflaging, despite experiencing resulting outward shifts in self-presentation and a degree of confusion. However, participants diagnosed with BPD struggled to reconcile contradictions in their identities and maintain one core sense of self.

Data integration

Findings from both the quantitative and qualitative datasets were integrated in a joint display to provide a richer, more comprehensive description of experiences of identity disruption in autistic participants and participants diagnosed with BPD (with the caveat that the qualitative sample also included a group of participants diagnosed with BPD who were diagnosed with autism or suspected they were autistic). The joint display is provided in Table 7.

While similar experiences of variable identity were expressed across all three qualitative groups, they appeared to be more characteristic of participants diagnosed with BPD in both samples. Qualitative findings suggested that participants across diagnoses reported consolidated, coherent, and continuous identities, even though difficulties with identity consolidation were significantly higher in the quantitative BPD group. Lack of identity experiences were more pronounced in participants diagnosed with BPD in both samples, and, in the qualitative interviews, similar difficulties appeared more transient and linked to adversity in autistic participants without a BPD diagnosis. Although camouflaging was only significantly associated with 'disturbed'/situational identity in the BPD group at $p_{adj} < .05$, camouflaging was qualitatively linked to some experiences of identity disruption, particularly in autistic participants. Camouflaging was described as more deliberate by autistic participants without a BPD diagnosis, compared to participants diagnosed with BPD, including those who were diagnosed with autism or who suspected they were autistic.

Discussion

Both autistic people and people diagnosed with BPD report identity disruption, yet the underlying mechanisms giving rise to these apparently similar experiences may be different. We conducted a secondary mixed-methods analysis focussing on how three domains of identity functioning—identity diffusion/variability, identity consolidation, and lack of identity—as well as camouflaging, are expressed in autistic adults and those with difficulties associated with BPD.

Summary and integration of findings

The hypothesis that items on the *Disturbed Identity* subscale of the SCIM would be equally characteristic of autistic participants and participants diagnosed with BPD, and would correlate with the camouflaging of autistic traits, was partially supported by our data. We found that scores on three of the eleven items did not differ between autistic participants and participants diagnosed with BPD, while the remaining eight were more characteristic of the BPD group. *Disturbed Identity* had a significant positive correlation with camouflaging in the BPD group, following an adjustment for multiple testing. In the qualitative interviews, participants across both diagnoses described context-driven changes in their identity. However, autistic participants without a BPD diagnosis appeared to use camouflaging more deliberately and while maintaining a core sense of self, whereas participants diagnosed with BPD experienced more underlying identity diffusion.

The quantitative data supported the hypothesis that *Lack of Identity*

Table 7
Joint display of quantitative and qualitative findings.

Comparison Strand	Quantitative Data	Qualitative Data	Meta-Inferences and Interpretation
'Disturbed'/ Situational Identity	• Total scores on the *Disturbed Identity* subscale of the SCIM were significantly higher in the BPD group than the autistic group (M_{BPD} = 42.6, SD_{BPD} = 11.2, M_{Autism} = 32.7, SD_{Autism} = 10.6, d = 0.91, p_{adj} <.001) • Average scores on all items, aside from 4, 12, and 21, were higher at p_{adj} < .05 in the BPD group.	• Experiences of fluid identity, driven by contextual factors, were reported by participants in all three qualitative groups. • Autistic participants appeared to maintain a sense of core identity despite overt shifts in expressions, while participants diagnosed with BPD (including those who were diagnosed with autism or who suspected they were autistic) tended to experience identity uncertainty, particularly in the presence of others, and contradictory traits.	• **Convergence:** Experiences of pervasive identity contradictions or fluctuations linked to the presence of other people appeared more characteristic of BPD, aligning with the quantitative findings. • **Expansion:** The qualitative findings suggest that some experiences of identity fluctuation in response to different social contexts or environments may appear across autism and BPD and may be expressed similarly.
Consolidated Identity	• Total scores on the *Consolidated Identity* subscale of the SCIM (reverse-scored such that higher scores indicate more problems with identity consolidation) were significantly higher in the BPD group than the autistic group (M_{BPD} = 40.6, SD_{BPD} = 9.5, M_{Autism} = 29.6, SD_{Autism} = 7.3, d = 1.29, p_{adj} <.001). • Average scores on all items were higher at p_{adj} < .05 in the BPD group.	• Experiences of strong, stable beliefs; relatively consistent and continuous self-concepts; and identity growth/ reconciliation following adversity were shared by participants across the groups. • It appeared that for some autistic participants, alexithymia experiences hindered identity consolidation, and for others, an autism diagnosis aided this process. • Some participants in the BPD-only group reported stable and consistent self-concepts and rejected the idea of a "wishy washy" (P305)	• **Divergence:** Similar experiences of identity consolidation and continuity were reported qualitatively across the three groups, despite the quantitative groups showing a significant difference. Several autistic interview participants described distinct barriers to and facilitators of identity consolidation. This may suggest identity consolidation was experienced differently in autistic participants compared to participants diagnosed with BPD.

(*continued on next page*)

Table 7 (*continued*)

Comparison Strand	Quantitative Data	Qualitative Data	Meta-Inferences and Interpretation
		identity, while some autistic participants struggled with some aspects of self-understanding.	
Lack of identity	• Total scores on the *Lack of Identity* subscale of the SCIM were significantly higher in the BPD group than the autistic group (M_{BPD} = 27.6, SD_{BPD} = 7.7, M_{Autism} = 17.9, SD_{Autism} = 7.6, d = 1.27, p_{adj} <.001). • Average scores on all items were higher at p_{adj} < .05 in the BPD group.	• Autistic participants without a BPD diagnosis did not appear to experience identity loss and associated emotional distress to the same degree as participants diagnosed with BPD (including participants who were diagnosed with autism or who suspected they were autistic), though some reported temporary identity loss following adversity or trauma.	• **Convergence:** Lack of identity was primarily associated with BPD in both strands. • **Expansion:** The qualitative data suggests that experiences of identity loss might be more transient and externally driven in autistic participants without a BPD diagnosis, whereas a BPD diagnosis may be linked to more enduring associated distress.
Camouflaging	• Total CAT-Q scores were significantly lower in the BPD group than the autistic group (M_{BPD} = 98.3, SD_{BPD} = 29.2, M_{Autism} = 124.2, SD_{Autism} = 21.4, d = 1.01, p_{adj} <.001). • The three SCIM items not differing between the autism and BPD groups described experiences of imitating others. These items appear conceptually aligned with some aspects of camouflaging. • Correlations between the CAT-Q and SCIM *Consolidated Identity* and *Lack of Identity* were not significant at p_{adj} < .05 in the whole sample, in the autism group, or the BPD group.	• Experiences of changing behaviour to align with demands of social contexts were reported in both groups, though autistic participants without a BPD diagnosis reported engaging in more deliberate camouflaging to reduce the perception of their differences, while often retaining a core sense of self. Participants diagnosed with BPD appeared to change their behaviour less deliberately, and those who also believed they were autistic or were diagnosed with autism reported some inauthenticity arising from camouflaging, whilst finding it difficult to	• **Convergence:** Deliberate camouflaging, including imitation of others, was more characteristic of autistic participants in both strands. • **Divergence:** Whilst only one significant association was found in the quantitative strand, participants across groups reported some identity disruption linked to camouflaging. • **Expansion:** Some participants diagnosed with BPD reported similar experiences of camouflaging, though these appeared less conscious. The quantitative data suggested a link between camouflaging and disturbed identity that was

Table 7 (*continued*)

Comparison Strand	Quantitative Data	Qualitative Data	Meta-Inferences and Interpretation
	• The correlation between the CAT-Q and SCIM Disturbed Identity was only significant in the BPD group (r (49) = .40 [.14,.61], p_{adj} = .039)	articulate a core sense of identity. Early traumatic or adverse experiences were described as linked to camouflaging across both groups.	unique to the BPD group.

and difficulties with *Consolidated Identity* would be more characteristic of the BPD group. As predicted, *Consolidated Identity* and *Lack of Identity* did not significantly correlate with camouflaging in either group. The qualitative data showed a more nuanced picture: many participants, across groups, reported clear, consolidated identities despite any outward variability or camouflaging, thereby partially aligning with the quantitative findings. Lack of identity was nearly exclusively described by participants diagnosed with BPD, including in the context of using the 'empty' self to avoid rejection. Autistic participants without a BPD diagnosis, on the other hand, tended to report temporary loss or disruption of identity linked to adversities such as depression or trauma, rather than a pervasive sense of lack of identity seen in participants diagnosed with BPD.

Interpretation of findings

The three items on the *Disturbed Identity* subscale which did not differ between autistic participants and participants diagnosed with BPD captured experiences of imitating or aligning their identity with other people. These items appear to conceptually align with social camouflaging described by autistic people. While the *Disturbed Identity* subscale was significantly correlated with camouflaging in both groups prior to adjustment, only the association in the BPD group remained significant post-adjustment. This may suggest some degree of overlap between the two constructs, though the extent of this association might differ between diagnostic groups. However, the quantitative findings should be interpreted with caution, given the small sample size. The qualitative findings suggested that situational changes in identity may not necessarily reflect 'personality pathology' but can instead be seen as adaptive responses to hostile social environments across these diagnostic groups. The results, therefore, provide partial support for our conjecture that the camouflaging of autistic traits might mimic aspects of identity diffusion or variability. One possible explanation is that different social contexts drive different self-presentation states for autistic individuals which could therefore be perceived differently (Ai et al., 2022; Khudiakova, Alexandrovsky, et al., 2025; Khudiakova, Levy, et al., 2025). This area of overlap may create scope for clinical conflation of adaptive and strategic behaviour modification strategies with BPD-aligned identity 'pathology'. Whilst we did not examine how such interpretations may arise in clinical practice, this study may provide a useful starting point for future investigations of the content of some items on the SCIM, as well as perceived 'identity disturbance', as possible sources of misinterpretation or unwarranted pathologisation of people's experiences.

Within the quantitative sample, autistic people reported fewer identity difficulties compared to those diagnosed with BPD, and in the qualitative strand, autistic participants without a BPD diagnosis generally reported more consolidated and certain identities. One explanation is that autistic people, at least with low levels of BPD-associated difficulties, may find it easier to maintain a core sense of identity, even though it may be narrated and expressed differently from non-autistic people (Pearson et al., 2026). However, some of our autistic

participants, in line with past qualitative literature (Howe et al., 2023; Hull et al., 2017; Leedham et al., 2020; Seers & Hogg, 2023), linked prolonged camouflaging to experiences of identity disruption, through perceived inauthenticity and identity incongruence. This type of disruption appears to stem more from a conflict between the 'real' and 'camouflaged' self, presupposing a more stable, core identity, which appeared to be echoed by some of our participants. Notably, this interpretation would be consistent with past research suggesting that, in autistic people, the *intent* to camouflage (i.e., the *Assimilation* subscale of the CAT-Q) may be more consistently related to poor mental health outcomes, compared to specific camouflaging strategies (Khudiakova et al., 2024); perceived identity incongruence may be a worthwhile candidate mechanism to examine in this context, including longitudinally. In contrast, our participants with a BPD diagnosis appeared to report more distress associated with rejection and lack of identity. It is plausible that people diagnosed with BPD may deploy strategies resembling camouflaging accordingly, possibly with different outcomes (Ai et al., 2024; Khudiakova, Alexandrovsky, et al., 2025). Petrolini and Schmidt-Boddy (2025) propose that people diagnosed with BPD may deliberately use strategies resembling camouflaging to mask identity disruption and identity loss, as opposed to differences in processing social interactions. This did not appear evident in our sample, as our participants diagnosed with BPD appeared to camouflage less deliberately and did not mention such motivations. Further research should explore impression management motivations, enactments, and consequences across these groups in more detail. In addition, the applicability of the construct of 'camouflaging' to non-autistic people diagnosed with BPD, along with its distinction from other forms of impression management, should be critically examined, given that concepts (and measures, in the case of the CAT-Q) developed with one clinical population in mind may not necessarily translate to others. For example, Adamou (2026) cautions against applying the construct of 'camouflaging' to attention deficit/hyperactivity disorder prior to appropriate validation.

Our findings also suggest that the three examined aspects of identity disruption may co-exist, evolve over time, and be expressed contextually. Diagnosed and suspected autistic participants with a BPD diagnosis, in particular, experienced both context-driven identity variability and painful lack of identity. The co-occurrence of these may pose particular concern, as those with co-occurring autistic and BPD traits are more likely to experience suicidal ideation (Chabrol & Raynal, 2018; Rydén et al., 2008). The interplay of internal factors (such as alexithymia) and external pressures (trauma or perceived pressures to camouflage) and their potential impacts on mental health might possibly account for the co-occurrence of these forms of identity disruption, warranting further longitudinal research. Furthermore, across both diagnostic groups, our qualitative data suggested that identity diffusion could sit alongside a preserved capacity to form stable and coherent identities that incorporate positive qualities. Strong alignment with core values were characterised as contributing to identity consolidation, including following traumatic experiences, therefore demonstrating how identity functioning may evolve over time. It is important to recognise and value these important aspects of identity when working clinically.

Limitations and future directions

Our study has several important limitations. In order to increase the representativeness of our quantitative sample, we used carefully specified adjusted thresholds on our screening measures to include individuals with subclinical traits of the comparator diagnosis, as long as they were unlikely to meet full diagnostic criteria (Barnicot et al., 2026). However, as individuals with very high levels of traits of the opposing diagnosis and thus deemed likely to meet criteria for both autism and BPD were screened out, these findings may not be fully representative of the wider autistic or BPD populations where there may be more overlap between the diagnoses (Dudas et al., 2017; McQuaid et al., 2024).

For both the SCIM and CAT-Q, further research with larger samples is needed to explore the potential for differential item functioning and measurement invariance in autistic people, people diagnosed with BPD, and those meeting criteria for both. In particular, while the SCIM has been validated in clinical and non-clinical samples (Kaufman et al., 2015, 2019), psychometric research supporting its use in autistic people is lacking. Questionnaires not designed or validated for autistic people may be inaccessible, particularly if they contain imprecise or ambiguous wording (Nicolaidis et al., 2020), potentially leading to autistic participants interpreting the questions differently from participants with a BPD diagnosis and low autistic characteristics. The converse may hold for the CAT-Q. Furthermore, the CAT-Q may be less effective in capturing prolonged, ingrained, or automatic experiences of camouflaging (Cook et al., 2021; Hannon et al., 2023), which have been linked to identity uncertainty in autistic people in qualitative research (Hull et al., 2017).

The qualitative interviews did not target identity functioning specifically, instead focusing on exploring a wider range of experiences. Coupled with the SCID only including few questions targeting identity disruption, the amount and depth of available data in relation to the domains of interest might be limited. Therefore, it is possible that our analysis did not capture all aspects of identity disruption in autistic people, as well as potentially protective and positive aspects of identity, such as agency (Schwartz et al., 2005) and authenticity (Evans et al., 2024). With regards to considerations of information power (Malterud et al., 2016), the interviews contained rich, nuanced, and illustrative accounts relevant to the present analysis, thereby allowing for an in-depth analysis of commonalities and heterogeneities within each group, though we acknowledge that some characteristic and distinguishing factors may not have been captured due to the aforementioned limitations. Future research should thus explore dimensions of identity functioning inductively in autistic people, focusing not only on expressions and experiences of identity disruption, but also on positive or eudaimonic identity functioning (Mao et al., 2016; Pearson et al., 2026), to understand whether these experiences differ from what is observed in non-autistic populations without relying on frameworks that may not capture autism-specific factors.

The scope of the present paper also meant that we were unable to explore other highly relevant mechanisms of identity disruption, for instance, (complex) trauma and attachment patterns (Herman, 1992; Waterman, 2020); the role of diagnostic timing, post-diagnostic changes in one's self-concept, and psychological treatment in alleviating identity disruption (Benjamin et al., 2025; Corden et al., 2021; Leedham et al., 2020; O'Connor et al., 2022); the effects of a BPD diagnosis and any associated stigma (Pereira Vargas et al., 2024; Tamilson et al., 2025); and the potential role of overlapping mental health and neurodevelopmental conditions (e.g., a drive for novelty in attention deficit/hyperactivity disorder may give rise to changeable interests, which could mimic difficulties in identity consolidation; Lasky et al., 2016). The intersections of these factors with camouflaging and identity functioning should be explored in autistic people and those with a BPD diagnosis, including individuals meeting criteria for both diagnoses. We also acknowledge that not all members of the 'combined' autism and BPD group in the qualitative strand had a confirmed autism diagnosis, and without a diagnostic assessment, it cannot be determined whether an autism diagnosis would be clinically appropriate for them. This should be taken into consideration when interpreting the results from this group, in addition to the barriers to diagnosis encountered by women and AFAB people diagnosed with BPD (Tamilson et al., 2025).

Finally, both samples were nearly entirely white and not reflective of the ethnic diversity of the UK population. Future studies should explore identity functioning in ethnically and racially minoritised autistic people and people diagnosed with BPD, as experiences of acculturation, racism, and within-community prejudice may exert distinct impacts on identity in these groups (Benedetto, 2024; Benjamin et al., 2025; Lei et al., 2024).

Conclusions

Our study highlights several key areas of overlap and distinction in identity functioning and expression in autistic women and AFAB people, and women and AFAB people diagnosed with BPD. The quantitative findings demonstrated that while participants diagnosed with BPD reported significantly more difficulties across three domains of identity functioning, some aspects of identity variability/'diffusion' (as per the *Disturbed Identity* SCIM subscale) linked to imitating others were endorsed equally by autistic participants. CAT-Q scores were associated with *Disturbed Identity* only in the BPD group, warranting further investigation. Our qualitative findings suggested that autistic participants and participants diagnosed with BPD engaged in similar identity management strategies, such as strategic adaptation. However, these seemed to be more deliberate in autistic participants without a BPD diagnosis, while participants diagnosed with BPD described greater underlying feelings of identity contradiction and emptiness. Clinicians should therefore be mindful of these distinctions and the possibility of camouflaging, in autistic people and those with a BPD diagnosis, and consider these in delivering appropriate and affirming supports.

CRediT authorship contribution statement

Valeria Khudiakova: Writing – original draft, Formal analysis, Conceptualization. **Jacqueline Sin:** Writing – review & editing, Supervision, Methodology. **Elissa Thompson:** Writing – review & editing, Methodology, Investigation, Validation. **Jennie Parker:** Writing – review & editing, Validation, Methodology, Investigation, Funding acquisition. **Kirsten Barnicot:** Writing – review & editing, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization, Supervision.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.rin.2026.100084.

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