The Autism Wave with Dr. Cummings

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In today's episode of the podcast, we are joined by Dr. Michael Cummings to discuss the most recent and popular diagnosis wave of individuals believing they may have autism, which has become a recent TikTok phenomenon.

Dr. Cummings notes that during his many years of practice, he has seen different diagnoses go through periods of popularity. When the general population becomes interested in certain diagnoses, it often results in an increase in people wondering if they have it and they often turn to mental health professionals to ask that question. However, we have found that what they are claiming to have does not present in the classical sense; it is somewhat manufactured. This episode hopefully helps you consider when someone does have autism, or when another diagnosis might be more likely the issue.

Limitations in Diagnoses Tools

When it comes to psychiatric diagnoses guidelines, in general, a limitation is that the diagnostic nomenclature is imprecise. There is the DSM-5 now, which does help with common agreement on diagnoses, but it is based on clustering symptoms together and blanketly stating that if a specific cluster is present then it is a specific illness. The problem is there is often a great deal of overlap or features among diagnoses.

Some argue that the whole system of categorical personality disorders is the wrong way to think about personality and personality functioning, instead favoring a dimensional analysis of personality.

ASD Diagnostic Considerations

Often, individuals with ASD have a propensity to be occupied with a very narrow range of interests, have very limited social interaction, and often, if they do interact with other people they clearly don't understand the social interaction. They will have difficulty with some abstract language concepts, appear to be unempathetic and unable to make an empathetic connection with others and at times, be either emotionally withdrawn or, if distressed, emotional labile.

People with autism do possess affective empathy, but have lower than average cognitive empathy. Affective empathy is the ability to feel into someone's experience. They may physically react to the emotions they perceive in those around them (it is common for non-verbal autistic patients to get agitated when mom and dad argue in front of them). Cognitive empathy is the ability to put into words someone else's experiences or their own experience and this is an ability they lack (unless trained). It can make them come off as narcissistic or unempathetic, but they do feel for others they just can't put words to it or relay it in a clear way.

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Autism as a Desirable Diagnosis

The diagnosis of borderline personality disorder, in particular, has a strong history of being pejorative. It is not surprising that people with this diagnosis would like something else as a diagnosis. Because of the prevalence of this negative connotation, Dr. Cummings strongly favors the ICD-11 definition "Disruptive Mood Dysregulation Disorder" vs. the DSM-5 definition of BPD because they renamed it mood dysregulation disorder, which does seem to be the heart of what BPD is. But someone with a mood personality disorder could have autistic characteristics, which is part of the symptom overlap that we encounter.

One comment on a social media post by Dr. Puder was from a school psychologist who observes that autism seems to be a coveted category of disability because it sounds better than saying your child has emotional disturbances.

Additionally, there is much more funding and resources available for people diagnosed with autism.

Another response to the post was a trending concern that if the child does have an affect regulation issue such as BPD, a misdiagnosis could keep them from receiving appropriate, effective treatments. If there is a misdiagnosis, there could be a permanence in the mind of the parent or patient that there won't be the ability to make the change. And though we have some psychosocial and pharmacological treatments, by and large we do not have an effective treatment for ASD.

Disorder Originations

With the historically negative connotation surrounding a BPD diagnosis, it is important to note that this is not something to be blamed on a person. Even if they meet the criteria for BPD, they did not create the mood lability that makes their life difficult and often miserable. So many affect regulation issues start in the first few weeks of life, seeming to be a temperamental inborn propensity, along with trauma, that leads to this issue. These patients are not choosing to have these issues.

Autism appears to start prior to birth. The best biological understanding is that the brain develops in a very sequential pattern of neurons initially with more connections than ultimately need be sustained. As the brain matures, excess neural connections are pruned away, allowing connections that do not work or fit well to atrophy. That process seems to be mistimed in those with autism so that the number of interconnections among neurons in the cortex is excessive. This may be one of the reasons they are prone to preoccupation and in some cases be savants. While every once in a while one of these extra connections may prove to be beneficial in some way, most of the non standard configurations are not beneficial.

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When Patients Claim Autism

When someone comes in with a self-diagnosis, approach with caution. Take time to find out a detailed description of the problems and get their history, mental status, and, in particular, how these issues have developed. In short, develop a profile before rushing to a diagnosis hypothesis. The whole reason we make a diagnosis is to try to match the person with the most effective treatment option available. Rushing into that or accepting a label without testing it first puts the person at risk for not receiving the treatment they need.

How Autism Differs From Other Disorders

Schizoid Disorders

The hallmark of schizoid personality disorder is someone who feels disconnected from others and is not bothered by being disconnected. They may lack the ability to verbalize what other people are feeling. They may possess both affective and cognitive awareness in terms of empathy, but, in essence, do not feel the need for connection the way most do. They may have some overlap to ASD, but are missing some of the critical components.

Schizotypal Personality Disorder

A classical eccentric individual does not quite fit social norms, but typically does not have the preoccupation, limited range of interests, or deficit in cognitive empathy. Their response to the world is often odd, but it is not ASD because they do not have those particular features.

Paranoid Personality Disorder

Most autistic individuals are not paranoid, even though they may be frightened or panicked at times. The hallmark of paranoid personality disorder is essentially to see conspiracies under every rock. It may start with a reasonable suspicion, but once they talk long enough we can see that the suspicion expands in terms of level of importance. Most autistic people do not feel that others are against them or are plotting to harm them.

Borderline Personality Disorder

Because of the emotional lability in people with BPD, they often have difficulty establishing stable relationships, but that is not the same difficulty that autistic patients have in connecting. BPD patients usually connect very well and very intensely, but it is a rollercoaster ride. They will have brief psychotic episodes and dissociations that don’t show up in autism. They also do not have issues with nonverbal communication the way someone with autism might or have the narrow interests characteristic of autism.

Psychopathy

Those with psychopathy have issues with affective empathy, while patients with ASD have issues with cognitive empathy. So patients with ASD can seem not empathetic, but they feel into other's experiences, even expressing it in their emotions (becoming emotionally distressed and agitated) but they cannot put it into words.

Narcissistic Personality Disorder

NPD can seem like autism when they are correcting other people's errors or lecturing others on their area of fascination, but narcissistic individuals do not have difficulty connecting with others due to normal amounts of cognitive empathy. However, the nature of the relationship is all about them, not about the other person. They see other people as objects to be used, while autistic individuals have a genuine connection to others, they just do not have language to express it. Narcissists may be superficially able to read people, but their empathy is lacking, as they are gearing their world to support their forward movement. As long as a person supports that goal, they are happy to have them as a part of their world.

Obsessive-compulsive Personality Disorder (OCPD)

OCPD is often phenotypically the most difficult to distinguish from autism because the preoccupation and singular focus can look very similar to autism. With each, individuals become incredibly preoccupied with details and want to minimize their interests into a very narrow range. OCPD individuals often seem more interested in imposing their rigidity and preoccupation on other people to a much greater extent than autistic individuals do. Someone with OCPD can be very difficult to treat because they often cannot grasp the big picture; they are entirely focused on the details. They don't lack the ability to connect with other people or the ability to put things into words.

A thought to go back to is that autism was originally described as a language developmental disorder and almost all autistic individuals have as a central feature the inability to put things into words.

Differentiating Personality From Personality Disorder

Essentially, the difference is flexibility. We all have a variety of aspects to our personalities. If we are healthy, we can shift which aspect of our personality is more prominent based on circumstances and context. In some ways, what is giving people with personality disorders difficulties is the inability to make the shift, unable to exhibit flexibility. A person with OCPD has a very difficult time switching from being detail-oriented while doing their accounting job to loosening up and being more free at a social engagement, instead of paying attention to if all of the napkins are lined up.

Also, while a person with ASD may have largely intact linguistic abilities, they lack the ability to intellectually understand the emotional experiences of other people. An OCPD person who stops long

enough from attending to details to think about what someone else is feeling has the capacity to process those experiences.

The Purpose of a Diagnosis

Labeling a patient is not always necessary or inherently helpful. There is the issue of the systemic nomenclature and overlap that can make a true diagnosis nebulous. When attempting a diagnosis, we need to carefully construct the history, symptom, and sign profile of the individual patient to find out what is getting in the way of their life in order to arrive at the most accurate diagnosis possible.

When a diagnosis may be helpful:

- From a psychopharmacological perspective, a diagnosis can be helpful for the purpose of matching the label that best fits with evidenced-based treatment for it.
- Some patients are looking for validation from a diagnosis that they have something real.
- An accurate diagnosis may be helpful for ourselves, whether we tell the patient or not, to get a sense of likely prognosis and what kind of support this person will need going forward.

The goal should be to find out what they want to change, what their goals are, what their biggest pain points are and how we get them moving forward from that. Finding out what is hindering their life, what they are wanting relief from—this is the ultimate goal and purpose of a diagnosis. What it comes down to is using the tools we have to find the best possible trajectory for our patients—to get them from where they are to where they want to go.

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Further Reading:

Bruno, A., Celebre, L., Torre, G., Pandolfo, G., Mento, C., Cedro, C., ... & Muscatello, M. R. A. (2019). Focus on Disruptive Mood Dysregulation Disorder: A review of the literature. *Psychiatry research*, *279*, 323-330.

Dell'Osso, L., Cremone, I. M., Carpita, B., Fagiolini, A., Massimetti, G., Bossini, L., ... & Gesi, C. (2018). Correlates of autistic traits among patients with borderline personality disorder. *Comprehensive Psychiatry*, *83*, 7-11.

Hofvander, B., Delorme, R., Chaste, P., Nydén, A., Wentz, E., Ståhlberg, O., ... & Leboyer, M. (2009). Psychiatric and psychosocial problems in adults with normal-intelligence autism spectrum disorders. *BMC psychiatry*, *9*(1), 1-9.

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-cited 952 times

Anckarsäter, H., Stahlberg, O., Larson, T., Hakansson, C., Jutblad, S. B., Niklasson, L., ... & Rastam, M. (2006). The impact of ADHD and autism spectrum disorders on temperament, character, and personality development. *American Journal of Psychiatry*, *163*(7), 1239-1244.

Lai, M. C., & Baron-Cohen, S. (2015). Identifying the lost generation of adults with autism spectrum conditions. *The Lancet Psychiatry*, *2*(11), 1013-1027.