Distinguishing between autism and the consequences of early traumatisation during diagnostic assessment: a clinical case study

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Abstract

Purpose – *Distinguishing between autism characteristics and trauma-related symptoms may be clinically challenging, particularly in individuals who have experienced early traumatisation. Previous studies have described a risk that trauma-related symptoms are misinterpreted and/or misattributed to autism. This study aims to describe and explore assessment strategies to distinguish autism and early traumatisation in the case of a young woman with mild intellectual disability.*

Design/methodology/approach – *A clinical case study outlining assessment strategies, diagnostic decision-making and initial intervention.*

Findings – *A multi-informant interdisciplinary assessment using multiple assessment tools, together with a comprehensive review of records from previous assessments and contacts with various services, was helpful in distinguishing between autism and trauma. This included specific assessment tools for autism and trauma. Autism characteristics and trauma-related symptoms appeared to interact, not merely co-occur.*

Originality/value – *The current case demonstrates that diagnostic overshadowing may occur for autism in the context of early trauma. The case further highlights the importance of not ascribing trauma-related symptoms to autism, as service provision and treatment need to take account of both. Overlooking autism in individuals who have experienced early traumatisation may result in a risk that intervention and care are not appropriately adapted, which may involve a risk of exacerbating trauma symptoms.*

Keywords *Assessment, Autism, Intellectual disability, Post-traumatic stress disorder, Trauma, PTSD*

Paper type *Research paper*

Introduction

Post-traumatic stress disorder (PTSD) is a common sequela following exposure to potentially traumatic experiences, involving symptoms of intrusion, avoidance, altered arousal/reactivity and negative changes to mood and cognition [American Psychiatric Association, 2022; World Health Organization (WHO), 2018]. Complex PTSD involves problems in affect regulation, negative self-concept and difficulties sustaining interpersonal relationships, in addition to the core symptoms of PTSD (Maercker *et al.*, 2022; WHO, 2018). Complex PTSD is typically associated with events that are prolonged or repetitive and from which escape is difficult (Maercker *et al.*, 2022; WHO, 2018).

Autistic people have a high risk of potentially traumatic experiences throughout their lives, including adverse childhood experiences, in particular, negative interpersonal events, such as violence and sexual abuse (Christoffersen, 2022; Gibbs *et al.*, 2021, 2023; McDonnell *et al.*, 2019; Quinton *et al.*, 2024; Reuben *et al.*, 2021; Rumball, 2019). They also appear to

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be at increased risk of household adversity during childhood, including economic adversity and parental mental illness (Berg *et al.*, 2016; Hartley *et al.*, 2023). Similar findings have been made regarding people with intellectual disabilities (Christoffersen, 2022; McDonnell *et al.*, 2019; Mevissen *et al.*, 2016; Vervoort-Schel *et al.*, 2018).

The prevalence of PTSD appears to be higher among autistic people than in the general population (Haruvi-Lamdan *et al.*, 2020; Reuben *et al.*, 2021; Rumball *et al.*, 2021b), and though it is likely to be higher also among autistic people with co-occurring intellectual disabilities, knowledge is more limited for this specific population (Kildahl and Helverschou, 2024; Quinton *et al.*, 2024). Being autistic appears to affect the experience and consequences of exposure to potentially traumatic events, including the kind of events that may be perceived as traumatic and the risk of consequent PTSD (Kerns *et al.*, 2015, 2022; Kildahl *et al.*, 2020b; Rumball *et al.*, 2023; Quinton *et al.*, 2024). While studies have concluded that PTSD criteria are applicable to autistic people (Rumball *et al.*, 2023), including those with co-occurring intellectual disabilities (Kildahl *et al.*, 2020b), the specific symptom manifestations may be affected by the individual's autism characteristics, level of intellectual disability, verbal language skills and other characteristics (Kerns *et al.*, 2015; Rumball *et al.*, 2023; Kildahl *et al.*, 2020b; Quinton *et al.*, 2024). Also, there appears to be a risk that PTSD symptoms are primarily observable to others as "challenging" behaviours (Kildahl and Helverschou, 2024; Kildahl *et al.*, 2019, 2020a; Rittmannsberger *et al.*, 2020), which may be misinterpreted.

Mental health assessment is challenging in autistic people with intellectual disabilities as they may have difficulties verbally reporting symptoms and experiences, difficulties making abstractions regarding their own behaviours, as well as lack of appropriate assessment tools and atypical symptom manifestations (Deb *et al.*, 2022; Kildahl *et al.*, 2024). Thus, mental health assessments in this population often rely on proxy reports. However, such reliance may involve a risk of overlooking conditions in which the most distinctive symptoms are subjective, such as PTSD (Kildahl *et al.*, 2024). Stress, anxiety and trauma are common in autistic people (Lai *et al.*, 2019; Rumball, 2019), and it has been suggested that clinicians may become so accustomed to such co-occurring difficulties that they see them as inherent to being autistic (Kildahl and Helverschou, 2024). In line with this, research indicates that PTSD may frequently be overlooked or misdiagnosed in autistic people (Kildahl *et al.*, 2019, 2020b; Kildahl and Helverschou, 2024; Rumball *et al.*, 2021a; Rumball *et al.*, 2023).

Conversely, there may be a risk of overlooking or misdiagnosing autism as borderline personality disorder (BPD) in early traumatisation (Rumball *et al.*, 2023), particularly in girls and women (Kentrou *et al.*, 2024). Such misdiagnoses involve a risk of longer treatment courses and diagnostic pathways (Kentrou *et al.*, 2024), and are perceived by autistic adults as a barrier to receiving appropriate support (Au-Yeung *et al.*, 2019). Mental health professionals appear to have negative attitudes towards individuals diagnosed with BPD (McKenzie *et al.*, 2022), which may affect professionals' willingness to engage with potential re-assessment. Moreover, severe early childhood neglect and abuse may result in developmental problems, including atypical language development and autism-like presentations (Naughton *et al.*, 2013), further complicating differential diagnostic assessment. However, establishing cause and effect for developmental difficulties in children having experienced early adversity remains challenging, as other findings indicate that autistic children and children with intellectual disabilities are overrepresented among these children (Christoffersen, 2022; McDonnell *et al.*, 2019).

The current recommendations for mental health assessment in people with intellectual disabilities emphasise the establishment of a baseline for autism characteristics, intellectual functioning, distress, behaviour, adaptive functioning and potential symptoms (Deb *et al.*, 2022; Kildahl *et al.*, 2024). This baseline is compared to the individual's current functioning, using multiple assessment tools and sources of information, as reliance on a single assessment tool or source of information may involve a risk of bias (Halvorsen *et al.*, 2024; Kildahl *et al.*, 2024). However, early traumatisation is likely to affect the individual's

development across several of these domains, including coping strategies, interpersonal functioning and personality traits (Maercker *et al.*, 2022; Naughton *et al.*, 2013). Thus, establishing a baseline for comparison is more challenging when trauma occurs in infancy or early childhood, and the consequences of early traumatisation appear more challenging to disentangle from the individual's underlying characteristics.

In the current study, we aim to describe and explore the assessment strategies used to distinguish between autism and the consequences of early traumatisation in the clinical case of a young woman diagnosed with an autism spectrum disorder, mild intellectual disability and complex PTSD.

Methods

Design

Case study methodology (Yin, 2014) exploring a single assessment was chosen to allow for in-depth exploration of assessment strategies. The participant was recruited from a tertiary mental health service for people with intellectual disabilities.

Research ethics

The current study was approved by the Data Protection Officer, Oslo University Hospital (#23/24286). The possibility of writing this manuscript was discussed with the patient, and she was eager to convey her story. She felt more understood following the current assessment, and felt her services were more adequately adapted, wanting others with similar difficulties to be understood sooner. The patient provided written consent, but because it was unclear whether she fully understood the consequences of such consent, also the patient's appointed legal guardian provided written consent. The patient was provided with a copy of the original manuscript prior to submission, as well as an opportunity to ask questions and discuss it with her service providers and a member of the assessment team and she reported no concerns with the manuscript or its contents. In addition, the patient's appointed legal guardian was provided with a copy of the manuscript prior to submission. The patient has been anonymised in the following presentation.

Case description

Referral and current situation

"Rebecca", a 24-year-old woman, was referred for a comprehensive diagnostic re-evaluation. At the time, she had diagnoses of mild intellectual disability, BPD and PTSD. The referral indicated suspicion of an additional attention deficit/hyperactivity disorder (ADHD). At intake, Rebecca was living in residential care with a designated direct service provider (DSP) available to her for day, evening and night shifts. In addition, she had regular appointments with a mental health nurse at an outpatient clinic.

Rebecca was reported to struggle with variable day-to-day functioning, including variable appetite and difficulties concentrating. On bad days, Rebecca was reported to withdraw and isolate, with staff reporting that she needed more care and help to feel safe. She had a very limited social network, but did interact with two family members. The suspicion of ADHD was based on observations that Rebecca appeared to be extremely impulsive. She had problems waiting and was perceived as "explosive" when things did not happen when she expected them to happen, as well as showing considerable restlessness and irritability. She frequently refused to interact with her DSPs, and they perceived her to be "intense and bossy". Reported depressive symptoms included sleep difficulties, depressive mood, sadness, withdrawal and reduced appetite. Rebecca also had difficulties initiating activities and struggled with any transition. It was reported that Rebecca frequently had difficulties understanding and could ask "1000 questions about the same thing". She had previously

shown aggressive behaviours, but her current aggressive outbursts were limited to throwing things and making threats. The referral reported concern about self-injurious behaviours, mainly superficial cutting.

Background and trauma history

Rebecca was diagnosed with a mild intellectual disability in her early school years. The reports indicated that Rebecca had difficulties regulating her emotions from early childhood, with head banging being a problem in early and middle childhood, often associated with emotional outbursts. Rebecca was also reported to have difficulties in social interaction, communication and rigidity from early childhood and was perceived as "different" from her siblings. She had not previously been assessed for autism spectrum disorder.

As for household adversity, Rebecca had experienced years of severe neglect in early to middle childhood, including substance abuse in the family and Rebecca taking a caregiving role for a family member who had a mental health disorder. Rebecca was placed in foster care in middle childhood. In the following years, Rebecca's life was characterised by instability, with conflicts between her parents and foster parents and frequent changes in placements. She received a more permanent placement in mid-adolescence, where she lived until she moved into her current residence as a young adult. There was a high degree of turnover among her current DSPs, meaning that in her adulthood, Rebecca experienced frequent loss of relationships.

Shortly after moving into residential care, Rebecca revealed that she had been sexually abused by a family member for several years during her early and middle childhood. The only source of this information was Rebecca herself. In addition, it had been documented by the child welfare services (CWS) that Rebecca had been physically abused, as well as witnessed frequent arguments and violence. Rebecca reported associating experiences involving child sexual abuse with feelings of helplessness, hopelessness and powerlessness. She reported having flashbacks and nightmares related to the abuse and had been diagnosed with PTSD. She also reported emotional instability, suicidal thoughts and self-injurious behaviours, feeling empty and numb inside, as well as occasional freeze responses, leading to a diagnosis of co-occurring BPD.

Assessment

The current assessment was conducted by an interdisciplinary team in the department's hospital-at-home unit, and included a clinical psychologist, psychiatrist, social worker and intellectual disability nurses specialising in mental health. The hospital-at-home service is an ambulatory alternative to inpatient treatment, involving the patient staying at home while having frequent/daily contact with hospital staff. On average, the team members have more than 10 years' experience from tertiary mental health services for autistic people and people with intellectual disabilities and are qualified in the assessment of neurodevelopmental conditions, as well as assessing and treating co-occurring mental health disorders in these populations. The team regularly conducts complex differential diagnostic assessments involving autism, intellectual disability, mental health disorder, as well as other co-occurring disabilities and health issues.

Records from previous contacts with any mental health or disability service were obtained, along with records from the CWS, educational services and medical services. The initial assessment focused on gaining an overview of Rebecca's current and previous cognitive and adaptive functioning, verbal language skills and any neurodevelopmental condition. The subsequent assessment focused more specifically on mental health symptoms, "challenging" behaviours and emotional development. A general medical examination and etiological/genetic assessment, including a review of previous pharmacological treatment,

were conducted as part of the assessment, in line with current recommendations (Deb *et al.*, 2022). Issues regarding consent, including capacity to consent, were attended to across all aspects of the assessment.

Despite the efforts of the assessment team to get to know and build a relationship with Rebecca, her difficulties in trusting new people and apparent chronic hyperarousal led to her experiencing considerable difficulties completing medical examinations and direct assessments involving self-report. Rebecca clearly stated that she wanted help from the specialist team, but reported finding these situations extremely stressful. It was, therefore, decided to limit reliance on interviews and direct examination, respecting Rebecca's wishes when she wanted to interact with the team and when she did not. However, this meant that the assessment relied more on interactions with the team and clinical observation in more informal settings, reports from Rebecca's DSPs and records from the CWS.

Assessment tools

Wechsler Adult Intelligence Scale-IV (WAIS-IV; Wechsler, 2008). Rebecca had previously been tested using the WAIS-IV, scoring in the range for mild intellectual disability. She had slightly higher scores for language-related skills than for working memory and perceptual reasoning.

Vineland Adaptive Behaviour Scales-III (VABS-III; Sparrow *et al.*, 2016). The VABS-III is a structured assessment tool for adaptive functioning. Rebecca scored in the expected range for mild intellectual disability on general adaptive skills, but scored higher for communication and daily living skills compared to socialisation. Within the communication domain, Rebecca's scores were significantly higher for expressive communication compared to receptive and written communication.

Behaviour Rating Inventory of Executive Function, Adult Edition (BRIEF-A; Gioia *et al.*, 2000). BRIEF-A is a checklist for executive functioning in adults, comprising 75 items rated on a three-point Likert scale. Rebecca's scores across the BRIEF were elevated, indicating problems across all domains of executive functioning.

Social Communication Questionnaire (SCQ; Rutter and Bailey *et al.*, 2003). The SCQ is a screening tool for autism spectrum disorder. Due to difficulties obtaining proxy reports concerning Rebecca's childhood functioning, only the SCQ current version was used. Rebecca obtained a score of 15, on the recommended cut-off. This included one item for difficulties in social interaction, while the remaining scores related to communication and stereotypic behaviour. The latter included behavioural inflexibility as well as a special interest.

Autism Diagnostic Observation Schedule-2 (ADOS-2; Lord *et al.*, 2012). The ADOS-2 is a semi-structured observation for autism assessment. ADOS-2 was attempted, but Rebecca showed clear signs of distress and did not want to continue. The ADOS-2 was, therefore, not completed.

Autism Diagnostic Interview-Revised (ADI-R; Rutter and Le Couteur *et al.*, 2003). The ADI-R is a semi-structured interview for assessment of autism spectrum disorder. Due to the lack of proxy reports from Rebecca's childhood, items in the ADI-R algorithm were scored based on examples and notes from detailed clinical observations described in Rebecca's extensive CWS records from her early and middle childhood. For the scoring, these notes and examples were interpreted in light of current clinical observations and records from previous assessments. Scores on the ADI-R indicated that Rebecca met the criteria for autism spectrum disorder.

Mini-Psychiatric Assessment Schedules for Adults with Developmental Disabilities (Mini-PAS-ADD; Moss *et al.*, 1997). The Mini PAS-ADD is a mental health assessment tool for people with intellectual disabilities. A total of 86 items are rated as "not in the last four weeks", "mild", "moderate" or "severe". Item scores are used to calculate scores for seven

subscales: depression, anxiety, hypomania, obsessive-compulsive disorder (OCD), psychosis, unspecified disorder and pervasive developmental disorder (autism). There are cut-offs for all subscales except the autism scale. Two DSPs were interviewed, with Rebecca scoring above the cut-off for hypomania in both interviews and for psychosis, anxiety and depression in one interview. The symptoms contributing to these scores were motor and psychological restlessness, difficulties relaxing, difficulties concentrating, lack of positive emotion, loss of interest and negative mood. Closer questioning regarding the hypomania symptoms indicated that the duration of these symptoms was shorter than required by the diagnostic criteria for hypomania and could often be triggered by impulse frustration or changes in Rebecca's environment. Both informants confirmed the presence of autism characteristics.

Psychopathology in Autism Checklist (PAC; Helverschou *et al.*, 2009). The PAC is a screening checklist for mental health disorder in autistic people with intellectual disabilities. A total of 42 items are rated on a four-point Likert scale from "not a problem" to "severe problem". The PAC was developed by identifying conventional symptoms of mental health disorders that do not overlap with autism characteristics (Helverschou *et al.*, 2008). Item scores are used to calculate five subscale scores: general adjustment difficulties, psychosis, depression, anxiety and OCD. Three DSPs were interviewed, with scores converging, see Table 1. She scored above the cut-off for general adjustment difficulties and depression in all interviews and above the cut-off for anxiety in two interviews.

Aberrant Behaviour Checklist (ABC; Aman *et al.*, 1985). The ABC is a checklist for "challenging" behaviours in people with intellectual disabilities. A total of 58 items are scored on a four-point Likert scale from "not a problem" to "severe problem". Item scores are used to calculate five subscale scores: irritability, social withdrawal, stereotypic behaviour, hyperactivity/noncompliance and inappropriate speech. While "challenging" behaviours are not specific to PTSD, previous studies have found associations between trauma/PTSD and the ABC scales irritability and hyperactivity/noncompliance (Rittmannsberger *et al.*, 2020; Kildahl and Helverschou, 2024). Three DSPs were interviewed, with some divergence in scores, see Table 1. Compared to previous population data (Myrbakk and von Tetzchner, 2008), the overall impression was that the scores were elevated for irritability, social withdrawal and hyperactivity/noncompliance.

International Trauma Questionnaire (ITQ; Cloitre *et al.*, 2018). The ITQ is a self-report diagnostic measure for PTSD and complex PTSD. The ITQ was scored by the psychologist

Table 1 Psychopathology in autism checklist and aberrant behaviour checklist scores at intake

Subscale	*Min-max.*	*Informant 1*	*Informant 2*	*Informant 3*	M
Psychopathology in Autism Checklist (PAC)					
General adjustment difficulties	1–4	2.25*	2.80*	2.00*	2.35*
Psychosis	1–4	1.80	1.60	1.90	1.77
Depression	1–4	2.90*	2.60*	2.00*	2.50*
Anxiety	1–4	1.80*	2.30*	1.50	1.87*
Obsessive-compulsive disorder	1–4	1.00	1.60	1.80	1.47
Aberrant Behavior Checklist (ABC)					
Irritability	0–45	17	28	11	18.67
Social withdrawal	0–48	10	12	12	11.33
Stereotypic behaviour	0–21	0	1	1	0.67
Hyperactivity/noncompliance	0–48	11	7	15	11.00
Inappropriate speech	0–12	3	2	7	4.00

Notes: PAC scores over the cut-off for each subscale (Helverschou *et al.*, 2009) are marked by an asterisk (*). Three staff members from Rebecca's residence were independently interviewed by nursing staff
Source: Authors' own work

based on information provided by Rebecca in interactions with the team. Rebecca confirmed symptoms of PTSD within all three domains (re-experiencing, avoidance, sense of threat), as well as in the three domains of complex PTSD (affective dysregulation, negative self-concept, disturbances in relationships) and was deemed likely to meet the ICD-11 criteria for complex PTSD based on this measure.

Lancaster and Northgate Trauma Scale-Intellectual Disabilities (LANTS-ID; Wigham *et al.*, 2011). The LANTS-ID comprises a 43-item informant-completed checklist and a self-report measure for trauma-related symptoms in people with intellectual disabilities. Only the informant-completed checklist was used, providing scores on three subscales: behavioural changes, frequency and severity. In line with the trauma occurring early in Rebecca's development, there were few scores for behavioural changes. As for frequency, scored on a six-point Likert scale, scores on individual items were either high or low, with most of the items scored as "daily" or "multiple times a day", resulting in a score for frequency of 168 (min 43, max 258). The DSPs confirmed a high frequency of repetitive behaviour, loss of adaptive skills, avoidance, verbal aggression, social withdrawal, guilt, reporting flashbacks, difficulties concentrating, hypervigilance, irritability, low self-esteem, negative mood, anxiety, need for validation, lack of trust, changes in appetite, repeatedly talking about worries, lack of interest in the future, disturbed sleep and lack of interest in activities. These symptoms were reported to have severe consequences for Rebecca's ability to function in her daily life.

Sensory Profile Checklist-Revised (SPCR; Bogdashina, 2016). The SPCR is an informant-completed checklist of behaviours indicating sensory hypo/hypersensitivities. Rebecca's scores indicated sensory dysregulation across several domains, including visual, auditory, tactile and taste-related stimuli.

Scale of Emotional Development-Short (SED-S; Sappok *et al.*, 2016). The SED-S is an informant-completed checklist for emotional development across eight developmental domains: relating to own body, relating to significant others, dealing with change/object permanence, differentiating emotions, relating to peers, engaging with the material world, communicating with others and regulating affect. Each domain is scored as one of five levels according to the age at which items occur in typical development. Rebecca scored in levels 4/5 (4–7 and 8–12 years) in 7/8 domains, while her score for "dealing with change/object permanence" was Level 2 (6–18 months).

General medical examination and genetic assessment. A comprehensive medical examination and genetic assessment was conducted, including EEG, MRI and a comprehensive pharmacological review, yielding no findings of physical or neurological problems that could explain Rebecca's difficulties.

Clinical observation and information from the patient

It was clear that Rebecca found interpersonal relationships challenging, and she reported that she never felt safe. She expressed a desire to feel safe, "but my body doesn't know what it means to feel safe". New DSPs were often rejected by Rebecca and struggled to build a relationship with her, contributing to the frequent turnover of staff. It was challenging for Rebecca to communicate that she was struggling and she would occasionally run away during difficult periods. She did not like other people making decisions for her, and any change in routines, schedules or staffing caused her distress. The assessment team interpreted these observations to indicate that Rebecca perceived even minor changes or disturbances as threatening.

During observations, Rebecca was perceived as passive and taking few initiatives, while at the same time not wanting others to make decisions for her. She appeared to associate specific activities with specific DSPs, meaning that if an activity had been established with a specific DSP, Rebecca had difficulties performing the same activity with others. This indicated to the assessment team that Rebecca had difficulties generalising across different DSPs.

Notably, while there was some divergence between different DSPs regarding "challenging" behaviours reported on the ABC, there was less divergence in reports of mental health symptoms, for example, on the PAC, see Table 1. This was interpreted as indicating that while Rebecca's behaviour differed across her relationships with her different DSPs, the reported mental health symptoms were present and could be observed across DSPs.

Rebecca had difficulties understanding her basic needs, including why she had to eat, sleep and participate in physical activity. Rebecca reported that bedtime was difficult for her because she associated it with the sexual abuse. Sleep avoidance was understood as Rebecca's way of coping with trauma, while also being unhelpful because it contributed to exacerbating other difficulties. Finally, it was observed that Rebecca had low self-esteem and lacked a sense of self-worth, resulting in a frequent need for confirmation and validation.

Results

Diagnostic conclusions

At referral, Rebecca had been diagnosed with a mild intellectual disability, PTSD and BPD. Following a comprehensive re-assessment, it was concluded that she met the criteria for a previously undiagnosed autism spectrum disorder. The autism diagnosis was based on extensive documentation of Rebecca's behaviour and functioning in childhood, assessment tools and clinical observation/judgement, all indicating that Rebecca met the diagnostic criteria for autism concerning social interaction, communication and repetitive/restricted behaviours and interests. The clinical impression was that her social and communicative difficulties were different from those typically seen in people with mild intellectual disabilities and complex PTSD and had a quality more often seen in autistic individuals.

The diagnosis of autism resulted in a need to re-evaluate the other diagnoses, leading to the clinical decision that complex PTSD was a more appropriate description of Rebecca's symptoms than a combination of BPD and PTSD. While Rebecca had some possible symptoms of ADHD, it was concluded that her difficulties in concentration and executive functioning could most likely be attributed to the combination of autism, complex PTSD and mild intellectual disability, in line with previous findings that complex PTSD is linked to difficulties in executive functioning (Op den Kelder *et al.*, 2017).

Treatment

The initial intervention aimed to provide Rebecca with a sense of safety, focusing on establishing trauma-informed care (TIC; Keesler, 2014; Truesdale *et al.*, 2019). To facilitate the introduction of TIC, the initial work consisted of establishing a shared understanding of Rebecca's abilities, difficulties and behaviours in line with the assessment results across the DSP group. Joint routines among staff were seen as important because Rebecca had difficulties generalising across DSPs. Thus, all individual staff members needed to work to establish a sense of *safety* in their specific relationship with Rebecca. The DSPs were told that Rebecca's frequent need for validation or confirmation was due to her trauma disorder and that she needed this validation when she asked for it. Explicit confirmation that she was safe in her home was emphasised, in addition to avoiding unnecessary changes to routines, to help Rebecca establish a sense of *trust* with DSPs.

As Rebecca responded poorly to others making decisions for her, *choice* and *collaboration* were emphasised by including written explanations of the things that Rebecca had difficulties understanding, as well as facilitated decision support. For example, adapted written information about the need for sleep appeared to help Rebecca establish an improved sleep pattern. An attempt was also made to modify situations that were difficult for Rebecca, for example, getting to know new staff members, in a way that could involve some sense of control for Rebecca to alleviate her sense of powerlessness. Finally,

empowerment, seeing Rebecca's perspective and opinions as important and valid, thereby requiring validation, was emphasised. This included apparent contradictions in her behaviour, such as being perceived as passive while also not liking others to make decisions for her. Such apparent contradictions were highlighted as something that should be explored with Rebecca in a non-judgemental way, in an attempt to understand. In total, the assessment team had 15 supervision meetings with the DSP group.

Rebecca participated in eight sessions with a therapist where she learned about autism, which she reported to find helpful, and she reported recognising herself as autistic. She asked to read her CWS records and received support for this. Thus far, the change in her DSP group has been positive, with fewer disagreements and an increasingly shared understanding of Rebecca's difficulties. She still displays several symptoms but does not run away as often. When Rebecca is more able to feel safe, she may benefit from more targeted trauma treatment and strategies for coping with emotional dysregulation.

Discussion

The current case involves a young woman previously diagnosed with mild intellectual disability, BPD and PTSD, where re-evaluation resulted in the patient being diagnosed with autism, the BPD diagnosis being removed, and the PTSD diagnosis being changed to complex PTSD. The case demonstrates how there is not only a risk of overlooking trauma-related disorder in autistic people but also risk of overlooking autism in people who have experienced early traumatisation. A multi-informant assessment using multiple assessment tools and conducting a comprehensive review of medical, psychological and CWS records was helpful in distinguishing between autism and early trauma.

Autistic people are overrepresented in individuals who have experienced early adversity and trauma (Christoffersen, 2022; McDonnell *et al*., 2019), suggesting a need for routine screening for neurodevelopmental conditions in this population, as well as the need for appropriate autism knowledge in the CWS. Experiences from the current assessment indicate that knowledge concerning the combination of autism, intellectual disability and complex PTSD was necessary to understand the patient's difficulties and adequately adapt support strategies. While the extent to which her unrecognised autism contributed to the frequent breakdowns in foster care placement is unclear, it is possible that she could have accessed more appropriate support at an earlier age, and thus avoided some of these breakdowns and consequent loss of caregivers had autism been recognised earlier in her life.

For the current patient, difficulties associated with autism and complex PTSD, respectively, did not appear to merely co-occur, but to interact and mutually affect each other. For instance, struggling with change and transition is not unusual among autistic people. While these difficulties were likely rooted in her autism-related difficulties, the patient's chronic alarm activation appeared to make her perceive change and transition as life-threatening, resulting in her reactions to change and transition appearing disproportionate and unusually intense to her DSPs, even if they were accustomed to working with autistic people. Similarly, some autistic people may have difficulties generalising across contexts and different social relationships. For the current patient, her autism-related difficulties in building social relationships with DSPs appeared to be exacerbated by her trauma-related difficulties trusting other people, as well as appearing to make it difficult for her to generalise across DSPs. These apparent interactions between autism characteristics and trauma-related symptoms highlight how these difficulties may appear intertwined to an observer, making them a challenge to disentangle from a diagnostic standpoint. This suggests that developmentally oriented and comprehensive assessments may be necessary to disentangle these phenomena. Moreover, this case highlights the importance of taking account of trauma and autism in service provision and treatment when these co-occur, as the associated difficulties and characteristics may interact in ways that exacerbate a person's difficulties if both are not taken into consideration.

While the assessment of autism was challenging, obtaining sufficient information to diagnose autism was made possible through a combination of patient records, informants reporting on the patient's current functioning and clinical observation. On the surface, it might be argued that the combination of mild intellectual disability and complex PTSD could have been sufficient to explain the patient's symptoms. However, clinical observation, the developmental perspective and descriptions from the patient's childhood suggest otherwise. Failure to recognise an underlying autism because surface symptoms overlap with complex PTSD is likely to involve a risk that treatment goals and service provision are not adequately adapted to the totality of the patient's difficulties. For example, if communication with the current patient is not adapted in line with an understanding of her as autistic, it is likely she will be met with excessive expectations and demands, involving the risk of a return to her previous experiences with service provision.

For the assessment of complex PTSD, a combination of information from patient records, information from the patient and two assessment tools proved helpful. The ITQ was scored based on information from the patient, and scores were in line with the diagnosis of complex PTSD. Similarly, scores on the LANTS-ID indicated the presence of a range of potential trauma-related symptoms. In light of the patient's extensive trauma history, the combination of these two assessment tools helped establish the diagnosis of complex PTSD, while other assessment tools, such as the SED-S, the VABS-III and the SPCR, helped in the process of individually adapting TIC for the patient. While not all services may have the resources to be able to conduct a similarly comprehensive assessment as the current one, these findings highlight the importance of considering potentially undiagnosed autism in early trauma and adversity and vice versa. These results further suggest that screening for either condition, for example, by using the SCQ and a trauma assessment tool, may be helpful in determining whether more comprehensive assessment is needed.

The current patient was misdiagnosed with BPD prior to being diagnosed with autism. There are surface overlaps in the diagnostic criteria for autism and BPD (May *et al.*, 2021; McQuaid *et al.*, 2024), and BPD appears to be a common misdiagnosis in late-diagnosed autistic individuals (Kentrou *et al.*, 2021, 2024). For the current patient, a comprehensive review of her history showed that she had social and communication difficulties from an early age. Failure to unearth the extent of these difficulties, overestimation of her social and communicative functioning, as well as her self-injurious behaviours, may have contributed to the misdiagnosis of BPD, in line with suggestions by McQuaid *et al.* (2024). This misdiagnosis likely contributed to the patient being viewed as demanding and difficult, which may have exacerbated her trauma-related symptoms because her behaviours were seen as deliberate rather than as a consequence of a chronic hyperarousal and inability to feel safe. The change in attitudes among DSPs is notable and in line with previous findings indicating that mental health professionals may have negative attitudes towards people diagnosed with BPD (McKenzie *et al.*, 2022). It appears likely that such negative attitudes may contribute to exacerbating co-occurring trauma-related symptoms for these patients, including in the current case. Failure to recognise autism may have further contributed to exacerbating the trauma-related symptoms because the patient struggled with demands that others took for granted and expected her to cope with, while she had no way of understanding why she struggled with these demands. After all, the patient's behaviour and functioning were similar before and after the re-assessment, showing how different diagnostic conceptualisations can apparently help or hinder in the establishment of appropriate treatment and service provision, in part, due to staff attitudes and understanding.

Limitations

The current study concerns a single case and has limited generalisability. The conditions covered in the differential diagnostic assessment are descriptive and diagnosed from lists of criteria that may overlap, highlighting the difficulties in such assessment, as well as the

inherent limitations of diagnostic assessment (Johnstone, 2018). Early adversity may have consequences for social and cognitive development (Naughton *et al.*, 2013), and it is not clear to what degree the patient's social, communicative and cognitive difficulties may be attributable to her childhood neglect and trauma.

None of the autism diagnostic tools could be completed in a standardised manner. While this may limit the confidence in the diagnosis of autism, autism remains a clinical diagnosis based on the clinical judgement of whether the patient meets the diagnostic criteria. In complex clinical cases such as the current one, it may not always be possible to complete the ADOS and the ADI-R in accordance with the recommended procedures. However, not diagnosing autism because the diagnostic assessment tools cannot be completed as recommended also constitutes a clinical judgement, which may have adverse consequences for the individual if they are autistic. Support from a speech and language therapist or an occupational therapist was not available in the current assessment, constituting another limitation.

As with other cases involving a high level of complexity, there are limitations with regard to the use of specific assessment tools, which may have limited validity in individuals with complex and compound conditions. In addition, several of the tools used in the current assessment have not been validated in autistic people with intellectual disabilities. Finally, the patient's difficulties limited the use of self-report measures. While reliance on informant reports constitutes a limitation, this is a common challenge in mental health assessment in people with intellectual disabilities (Deb *et al.*, 2022; Kildahl *et al.*, 2024). Several strategies were used to limit the potential influence of bias from these reports, including the use of multiple assessment tools and multiple sources of information (Halvorsen *et al.*, 2024; Kildahl *et al.*, 2024), as well as reflecting on and exploring divergence/convergence of information from different sources (Kildahl *et al.*, 2024).

Conclusions

The current case highlights the importance of attention to the co-occurrence of autism and trauma to avoid diagnostic overshadowing for either condition. A comprehensive review of patient records, multi-informant assessment using multiple assessment tools, direct observation by experienced clinicians and information from the patient herself helped establish the diagnoses of co-occurring autism, mild intellectual disability and complex PTSD. The findings from the current case highlight the importance of understanding the dynamic of trauma for each autistic individual, including how it may affect the manifestation of autism characteristics, to facilitate appropriate diagnosis and adequately adapted intervention.

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