

**Experience of Mental Health Diagnosis and Perceived Misdiagnosis in Autistic, Possibly  
Autistic and Non-Autistic Adults**

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### **Lay Abstract**

Research has shown that many autistic people are diagnosed with mental health conditions, but getting the wrong diagnosis is quite common. We asked four hundred and twenty-two adults who identified as autistic, possibly autistic (not yet diagnosed), or non-autistic about: their mental health diagnoses, if they agreed with those diagnoses, and if not why. Autistic and possibly autistic participants were more likely to have mental health diagnoses, but were less likely to agree with those diagnoses. When asked why they disagreed with their mental health diagnoses, autistic and possibly autistic participants said they felt: 1) their autism characteristics were being confused with mental health conditions by healthcare professionals, and 2) their mental health conditions were due to the difficulties they experienced as autistic people. Participants felt that these misdiagnoses were due to healthcare professionals' lack of autism awareness, and lack of communication with participants about their diagnosis and difficulties. This stopped participants getting the support they needed. It is recommended that: 1) healthcare professionals receive further autism awareness training, to improve mental health diagnosis and treatment; 2) diagnostic tools and treatment should be changed to better suit the needs of autistic people.

**Abstract**

Previous research shows that autistic people have high levels of co-occurring mental health conditions. Yet, a number of case reports have revealed that mental health conditions are often misdiagnosed in autistic individuals. Four hundred and twenty-two adults who identified as autistic, possibly autistic, or non-autistic completed an online survey consisting of questions regarding mental health diagnoses they received, whether they agreed with those diagnoses, and if not why. Autistic and possibly autistic participants were more likely to report receiving mental health diagnoses compared to non-autistic participants, but were less likely to agree with those diagnoses. Thematic analysis revealed the participants' main reasons for disagreement were that they felt: 1) their autism characteristics were being confused with mental health conditions by healthcare professionals, and 2) their mental health difficulties were perceived to be resultant of ASC. Participants attributed these to the clinical barriers they experienced, including healthcare professionals' lack of autism awareness and lack of communication, which in turn prevented them from receiving appropriate support. The current study highlights the need for autism awareness training for healthcare professionals, and the need to develop tools and interventions to accurately diagnose and effectively treat mental health conditions in autistic individuals.

### Introduction

Autism Spectrum Condition (ASC)<sup>1</sup> is classified as a neurodevelopmental condition, characterised by persistent difficulties in social communication and interaction, as well as restricted, repetitive patterns of behaviour, interest, and activities (APA, 2013). These symptoms present during early development and cause a range of strengths and difficulties in multiple domains. Recent studies suggest that autistic difficulties could increase the likelihood of being exposed to risk factors for developing mental health conditions. For example, higher autistic traits were associated with self-reported loneliness in autistic adults (Hedley, Uljarević, Foley, Richdale, & Trollor, 2018) and the experience of social disconnectedness, and feeling a burden on others in the general population (Pelton & Cassidy, 2017); these factors in turn increased the risk of both depression and suicidality. Indeed, Lever and Geurts (2016) established that 79% of autistic adults meet the criteria for some form of psychiatric co-occurring condition during their lifetime, with mood and anxiety disorders being the most common, and at a significantly greater rate compared to non-autistic adults.

Despite increased risk factors for, and incidence of, mental health conditions in autistic individuals, conditions such as depression may still be under-diagnosed given the lack of validated assessment tools able to accurately detect the unique presentation of mental health difficulties in this group (Cassidy, Bradley, Bowen, Wigham, & Rodgers, 2018ab). Although ASC is not a mental health condition, the characteristics of ASC can overlap with many indicators of mental health conditions; for example, social withdrawal, appetite and sleep disturbance are common characteristics in both ASC and depression (Stewart, Barnard, Pearson, Hasan, & O'Brien, 2006). This means that an established diagnosis of ASC could overshadow the presence of mental health symptoms, potentially leaving co-occurring mental health conditions unrecognised (Matson & Williams, 2013). The consequences of failing to accurately diagnose co-occurring mental health conditions are potentially devastating, and increase the risk of contemplating, planning (Cassidy et al. 2014) and dying by suicide (Hirvikoski et al. 2016).

It is also possible that symptom overlap could lead to over-diagnosis and misdiagnosis of mental health conditions in autistic individuals (Lai & Baron-Cohen, 2015). In a case series, Dosseter (2007) re-evaluated four young clients, aged eight to sixteen years, originally diagnosed with early onset psychosis. The individuals reported unusual experiences, exhibited bizarre behaviours, and had preoccupations with objects and imaginary people or worlds. However, when the clients' impairments

in social communication and reciprocity were taken into consideration, it was concluded that clients' presentation could be better explained by ASC, with the preoccupations accounted for under "restricted, repetitive patterns of behaviour, interest, and activities" (APA, 2013). Other case reports (Luciano et al., 2014; Van Schalkwyk, Peluso, Qayym, McPartland, & Volkmar, 2015) also indicated that mental health professionals' failure to collect information about developmental history, and lack of understanding about ASC presentation, contributed to mental health misdiagnoses in both individuals with an existing autism diagnosis, as well as those who obtained a diagnosis during the studies. Misdiagnosis of ASC as a mental health condition could lead to unnecessary treatment (e.g. medication), which could preclude the possibility of having other, more relevant, needs met.

While previous case studies (Dosseter, 2007; Luciano et al., 2014; Van Schalkwyk, et al., 2015) provide important clues to the contributing factors for mental health misdiagnosis in autistic individuals from the perspective of professionals specialising in ASC, there is currently little known about autistic individuals' subjective experience of mental health diagnosis and perceived misdiagnosis. Therefore, this paper aims to address the following research questions: 1) are autistic individuals more likely to report receiving mental health diagnosis/es and if so, what kind of diagnoses were they more likely to receive? 2) are autistic individuals more likely to disagree with these diagnoses?; and 3) what were the reasons behind any disagreement?

Three participant groups were included, comprising of individuals who either identified as autistic, non-autistic, or possibly autistic. Inclusion of the non-autistic group allowed us to examine if mental health diagnoses and perceived misdiagnoses were more common in autistic individuals compared to the general population. We included a group of possibly autistic people who reported suspecting that they may have an undiagnosed ASC. The reasons for this are that yet to be diagnosed autistic individuals may be particularly vulnerable to misdiagnosis of mental health conditions (Dosseter, 2007; Luciano et al., 2014; Van Schalkwyk, et al., 2015), and also that autistic individuals often play an important role in the recognition of their ASC. Jones, Goddard, Hill, Henry, and Crane (2014) looked at the experience of those who have received an ASC diagnosis, and found that 44.5% of their respondents reported raising the possibility of ASC themselves, in comparison to whereas only 4.1% reporting that a professional raised the possibility. It is also well-known that certain characteristics affect the likelihood of receiving an autism diagnosis, for example, females are diagnosed less frequently than males (Brugha, et al., 2001). This may be due to their differences in

presentation, such as better nonverbal communication skills and the ability to camouflage other diagnostic features (Rynkiewicz et al., 2016). Seeking a diagnosis in adulthood may be particularly problematic due to the development of compensatory strategies and a possible lack of informant (e.g. parent) for developmental history (Lai & Baron-Cohen, 2015). For these reasons, it is important for the experiences of this previously under-researched group, namely possibly autistic adults, to be heard.

## Method

### Materials

**Survey Development.** Research priorities for the autism community can be very different to those of researchers (Pellicano, Dinsmore, & Charman, 2014). Therefore, it is important that autistic people participate in setting priorities to ensure that research conducted is useful to those most affected by it (Fletcher-Watson et al., 2018). As such an online survey exploring various topics including mental health diagnoses, self-injury and suicidality, was developed in partnership with a steering group of eight autistic adults (six females, two males) through a series of six focus groups (see Cassidy, Bradley, Shaw, Baron-Cohen, 2018 for details of the full data set). At the start of the study, the steering group discussed what their role should be, and decided it would be to inform the study conception, design, recruitment and dissemination of results. The first three focus groups focused on developing the questions in the online survey about a number of topics identified from a systematic review of the literature thought to be important contributors to mental health and suicidality in autism. The focus group fed back on the relevance of these proposed topics, whether any important topics were missing, and their own experiences in relation to the topics identified. The researchers then developed a survey with questions that would allow participants' experiences of these topics to be captured. Once the survey had been designed, the steering group provided feedback on three drafts until agreement was reached that the questions were comprehensive, relevant and clear. The data collected in relation to mental health diagnoses was analysed and are reported in this paper. Data relating to other topics collected from the survey are reported elsewhere (see Camm-Crosbie, Bradley, Shaw, Baron-Cohen, & Cassidy, in press).

**Mental Health Diagnosis Questions.** Participants answered closed- and open-ended questions on their mental health diagnoses. Firstly, they were asked "Have you ever been diagnosed with a mental health condition(s) or other condition(s) by a trained clinician?" to which they responded with either "Yes" or "No". They were subsequently asked to select the specific mental health or other

condition(s) including: Depression, Anxiety, Obsessive Compulsive Disorder (OCD), Bipolar, Personality Disorder, Schizophrenia, Anorexia, Bulimia, and Other. If participants selected “Personality Disorder” or “Other” from the list, they were given a free text box to specify the subtype of Personality Disorder or other mental health conditions they were diagnosed with. Participants were then asked: “Do you agree with your diagnosis/es”, with response options: “Yes”, “No”, or “Not entirely”. If participants selected “No” or “Not entirely”, they were subsequently asked: “Please tell us what mental health diagnosis/es you disagree with, and why” and indicated their response using a free text box.

These diagnoses and order were chosen due to a combination of standard questions our group regularly uses in previously published research, and also feedback from the steering group regarding clarity. For example, participants noted that it was easier to have staged questions starting wide, and then narrowing (Personality Disorder then subtype), to keep the survey questions relevant throughout.

**Demographic questions.** As part of the survey, participants were asked to provide information such as age, gender, autism diagnosis and age of diagnosis. Participants were divided into three groups for analysis based on their autism diagnostic status. Participants in the *non-autistic group* reported no formal diagnosis of ASC and no suspicion that they have ASC. Participants in the *autistic group* reported receiving a formal diagnosis of ASC from a qualified clinician. Participants in the *possibly autistic group* reported that they thought they may have ASC, and either 1) were awaiting assessment from a qualified clinician or 2) had not yet sought an assessment.

**Autism Spectrum Quotient (AQ).** The AQ (Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001) is a measure of autistic traits with score ranged from 0 to 50. Greater score indicates higher levels of autistic traits. Participants rated themselves on 50 statements with the options “Definitely Agree”, “Slightly Agree”, “Slightly Disagree”, and “Definitely Disagree”. Woodbury-Smith, Robinson, Wheelwright and Baron-Cohen (2005) recommended a cut-off of 26 for screening in clinical practice and a cut-off of 32 for general population to limit false positives. We followed Hoekstra, Bartels, Verweij, and Boomsma’s methodology (2007) to manage missing items. If five or fewer items were left blank, the following equation was used to correct for the number of missing items: total subscale score + (mean subscale item score x number of missing items in subscale). The corrected

subscale scores were summed to get the total AQ score. Missing items accounted for 0.19% of the analysed data. If a participant left more than 5 items blank, their data were discarded. Two participants' data were excluded based on this criterion.

### Participants

Participants were recruited through charities, Cambridge Autism Research Database (CARD), Cambridge Psychology, online advertisement, MHAutism newsletter and MHAutism webpage (<http://mhautism.coventry.ac.uk>). Participants were invited to take part in an online survey exploring experiences of mental health problems, self-injury and suicidality, and could take part regardless of prior experience of these difficulties. Data from four hundred and twenty adults (18 to 67 years) who completed the "mental health diagnoses" section of the online survey were analysed. Data from respondents who did not report either their age ( $n = 52$ ), gender ( $n=3$ ) or diagnostic status ( $n=0$ ) were excluded. The autistic group was significantly younger than the non-autistic group ( $p = .013$ ), and there was a significantly greater proportion of males and smaller proportion of females compared to both the possible autistic and non-autistic group ( $ps > .05$ ). Welch's ANOVA revealed that there were significant between-group differences in AQ scores,  $F(2, 189)=281, p<.001$ . Autistic and possibly autistic participants scored significantly higher on the AQ than non-autistic participants ( $ps<.001$ ). Autistic participants also scored significantly higher than possibly autistic participants on the AQ ( $p=.005$ ). Participants' characteristics are reported in Table 1.

Table 1. Participants' characteristics.

	Autistic ( $n=208$ )	Possibly Autistic ( $n=71$ )	Non-autistic ( $n=141$ )
Mean Age ( $SD$ ), Range	38.6 (11.4), 18-67	40.1 (8.9), 20-57	42.1 (10.6), 20-60
Number of males	72 (34.6%)	11 (15.5%)	20 (14.2%)
Number of females	136 (65.4%)	60 (84.5%)	121 (85.8%)
Mean AQ ( $SD$ )	38.6 (6.8)	35.8 (5.9)	17.5 (8.7)
Mean Age of Diagnosis ( $SD$ ), Range	34.5 (12.2), 4-59		

### Procedure



The study was approved by Coventry University Psychology Ethics Committee, and was approved by the autism steering group who fed back on the questionnaire, and the scientific advisory group at the Autism Research Centre, University of Cambridge. Participants were invited to complete the survey on Qualtrics (<https://www.qualtrics.com/uk/>). Participants read the participant information sheet and indicated informed consent to participate via an online form. Participants were fully briefed about the nature of the research, that they could skip sections and/or questions that they felt uncomfortable with, and were provided information about relevant support services before and after participation.

## **Analysis**

**Quantitative Analysis.** Statistical Analyses were conducted using SPSS Version 24. Chi-square tests for homogeneity were computed to test for between-group differences in the proportions of 1) individuals reported receiving mental health and other diagnoses, 2) specific mental health diagnoses received, and 3) agreement with mental health diagnoses. If a Chi-square was significant, post-hoc z-tests were then computed to further examine pair-wise differences in group proportions with automated adjusted *p*-values (Bonferroni method). Fisher's Exact Tests was used instead if any of the expected cell count were less than 5. Cramer's V was calculated for effect size (small effect = .1, medium effect = .3, large effect = .5; Cohen, 1988).

**Qualitative Analysis.** Thematic analysis was conducted for participants' responses to the question "Please tell us what mental health diagnosis/es you disagree with, and why". Responses with no mention of the specific diagnosis/es they disagreed with were excluded. Braun and Clarke's (2006) methodology for thematic analysis were followed. This enabled exploration of the research question in a data-driven manner informed by participants' perspective and experience. SA read through the responses to gain an overall impression of the dataset and noted any emerging patterns. The responses were then reread and initial codes were generated. Codes describing similar concepts were grouped into preliminary themes and subthemes, which were subsequently reviewed by AR, LB and SC. Discussion amongst the authors led to further refinement of the themes. Thereafter, related themes and subthemes were consolidated, while those that were deemed to not meaningfully address the research question were discarded.

## **Results**

### **Rate of Lifetime Mental Health Diagnoses and Other Conditions**

There were significant between-group differences in the proportions of participants reporting mental health or other diagnoses,  $\chi^2(2) = 57.5$ ,  $p < .001$ ,  $V = .370$  (see Table 2). Autistic and possibly autistic participants were more likely to report receiving mental health or other diagnoses compared to non-autistic participants ( $p < .05$ ). There was no significant difference between autistic and possibly autistic participants ( $p < .05$ ).

Table 2. Number of participants who reported diagnosis of mental health condition or other conditions.

"Have you ever been diagnosed with a mental health condition(s) or other condition(s) by a trained clinician?"	Autistic ( $n=208$ )	Possibly Autistic ( $n=71$ )	Non-autistic ( $n=141$ )
Yes	183 (88%)	57 (80.3%)	74 (52.5%)
No	25 (12.0%)	14 (19.7%)	67 (47.5%)

Secondly, we compared the proportions of individuals reporting specific mental health diagnosis between groups (see Table 3 for omnibus test statistics and pairwise comparisons). Types of diagnoses that participants selected or mentioned were grouped for analysis based on DSM-5 classifications (APA, 2013). There were no significant between-group differences in proportion of individuals who reported diagnosis of Schizophrenia and Other Psychotic Disorders, Bipolar and Related Disorders, Dissociative Disorders, Gender Dysphoria, and Substance Related and Addictive Disorders. However, there were significant between-group differences in the proportion of individuals reporting diagnoses of Depressive Disorders, Anxiety Disorders, Obsessive Compulsive and Related Disorders, Trauma and Stressor Related Disorder, Feeding and Eating Disorders, and Personality Disorders, with consistently greater number of participants in the autistic and/or possibly autistic groups reporting these diagnoses.

Table 3. Number of participants who reported mental health diagnoses.

	Autistic ( <i>n</i> =208)		Possibly Autistic ( <i>n</i> =71)		Non-autistic ( <i>n</i> =141)		Omnibus Test	Pairwise Comparisons
Depressive Disorders	161	(77.4%)	52	(73.2%)	60	(42.6%)	$X^2(2)=.47.4, p<.001, V=.336$	ASC>NASC PASC>NASC ASC=PASC
Anxiety Disorders	148	(71.2%)	45	(63.4%)	48	(34%)	$X^2(2)=48.6, p<.001, V=.340$	ASC>NASC PASC>NASC ASC=PASC
Obsessive-Compulsive and Related Disorders	40	(19.2%)	8	(11.3%)	3	(2.1%)	$X^2(2)=23.1, p<.001, V=.235$	ASC>NASC PASC>NASC ASC=PASC
Personality Disorders	25	(12.0%)	8	(11.3%)	6	(4.3%)	$X^2(2)=6.41, p=.041, V=.124$	ASC>NASC ASC=PASC PASC=NASC
Feeding and Eating Disorders	21	(10.1%)	8	(11.3%)	4	(2.8%)	$X^2(2)=7.49, p=.024, V=.134,$	ASC>NASC PASC>NASC ASC = PASC

Bipolar and Related Disorders	12 (5.8%)	5 (7%)	2 (1.4%)	Fisher's Exact Test=5.49, $p=.051$ , $V=.108$	
Schizophrenia Spectrum and Other Psychotic Disorders	7 (3.4%)	3 (4.2%)	1 (.7%)	Fisher's Exact Test=3.49, $p=.149$ , $V=.087$	
Trauma- and Stressor-Related Disorders	6 (2.9%)	6 (8.5%)	1 (.7%)	Fisher's exact test=8.19, $p=.012$ , $V=.150$	PASC>NASC ASC=NASC ASC=PASC
Gender Dysphoria	2 (1%)	0 (0%)	1 (.7%)	Fisher's Exact Test=.505, $p=1.00$ , $V=.041$	
Dissociative Disorders	0 (0%)	1 (1.4%)	0 (0%)	Fisher's Exact Test=3.46, $p=.169$ , $V=.108$	
Substance-Related and Addictive Disorders	0 (0%)	1 (1.4%)	0 (0%)	Fisher's Exact Test=3.46, $p=.169$ , $V=.108$	

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*Note.* ASC = Autistic group, NASC = Non-Autistic group, PASC = Possibly Autistic group. More detailed analyses were carried out on the subtypes of personality disorders, but no significant between-group differences were found (see Supplementary Materials A).

### Disagreement with Mental Health Diagnosis

There were significant between-group differences in the proportions of individuals who reported disagreement with their mental health diagnoses as denoted in response to an open-ended question on this topic, Fisher's Exact Test=31.8,  $p<.001$ ,  $V=.218$  (see Table 4). Two of the post-hoc pairwise comparisons were significant: these were the 2 (non-autistic vs autistic) x2 (Yes vs Not entirely) comparison and the 2 (non-autistic vs possibly autistic) x2 (Yes vs Not Entirely) comparison (both  $ps<.001$ ). These showed that a higher proportion of autistic and possibly autistic participants did not entirely agree with their mental health diagnosis compared to non-autistic participants, while a greater proportion of non-autistic participants agreed with their mental health diagnosis compared to the other two groups. None of the other seven comparisons reached significance ( $ps>.05$ ). Proportions of participants who disagreed with specific type of mental health diagnoses were compared between-groups, but no significant differences were found (see Supplementary Material B).

Table 4. Number of participants who show agreement or disagreement with their mental health diagnosis.

"Do you agree with your mental health diagnosis/es?"	Autistic ( $n=182$ )	Possibly Autistic ( $n=57$ )	Non-autistic ( $n=74$ )
Yes	106 (58.2%)	26 (45.6%)	64 (86.5%)
No	12 (6.6%)	2 (3.5%)	3 (4.1%)
Not Entirely	64 (35.2%)	29 (50.9%)	7 (9.5%)

### Thematic Analysis

This section explored the reasons underlying disagreement with mental health diagnosis/es. Data for the autistic and possibly autistic participants were analysed together, because our quantitative analysis showed that both groups were significantly more likely to report disagreement with their mental health diagnoses compared to the non-autistic group (see Table 4). Therefore, it is likely that participants in the possibly autistic group have shared experiences with those in the autistic group. Spelling and grammatical errors were corrected in participants' extracts; these are denoted in square brackets in the quotes. Each quote is

followed by a participant number and their diagnostic status (ASC=autistic, PASC=possibly autistic). Data from the non-autistic group were not analysed as very few of these participants showed disagreement and responded to the open-ended question. Two major themes emerged from the thematic analysis: “Problems with Mental Health Diagnosis” and “Clinical Barriers”.

**Problems with Mental Health Diagnosis.** This theme consists of two sub-themes: ‘ASC characteristics confused with symptoms of a mental health condition’, ‘mental health difficulties perceived to be resultant of ASC’.

*ASC characteristics confused with symptoms of a mental health condition.* The first most common reason for participants’ disagreement with their mental health diagnoses was that they felt their ASC characteristics were mistaken as symptoms of a mental health condition. For example, in the following extract, an autistic participant explains how their difficulties with emotional regulation and self-injurious behaviours may have been misinterpreted as symptoms of a borderline personality disorder (BPD)<sup>2</sup>:

“... [it’s] just aspergers with me, the out coming behaviour might look or even be the same sometimes ([self-harm], getting [emotional] etc) but the causes are completely different- [I] learnt to hide my emotions and feelings to survive school and home without being hurt so only [got] visibly upset in the last moment when [it became] unbearable- just because they cannot read my face [doesn’t] mean [I’m] not having those emotions before. ...” (153-ASC),

The same participant also reported that their lack of eye contact was mistaken as evidence of schizophrenia rather than social communication difficulty in ASC:

“...I was given anti-psychotics for my behaviour... they think because [I don’t] look at them and [I] am nervous of talking then [I] am 'guarded' or have 'flat affect'...” (153-ASC).

One possibly autistic participant did not ‘entirely agree’ with their Trauma and Stressor Related Disorder diagnosis because they felt their difficulties with resistance to change could

be better explained by ASC, and specifically, the category of 'restricted, repetitive patterns of behaviour, interests, or activities' (APA, 2013).

"...I think that ties in with possibly having an ASC as not coping well with change is a characteristic of that" (445-PASC).

Similarly, another possibly autistic participant who received a bipolar disorder diagnosis felt their intense interest had been mistaken as signs of mania:

"...I get mood swings, but I believe that is more due to the Autism than manic depression. I am subdued when I am uncomfortable and what may look manic when I am doing something I like..." (238-PASC).

Some participants spoke about sensory sensitivities that they felt were mistaken as eating disorders or psychotic symptoms:

"My issues with food were regarding the texture and the act of eating" (452-PASC).

"I stopped going to the school canteen as a teenager and lost a lot of weight because I couldn't stand the social/sensory environment" (2-ASC).

"I am also not psychotic - I have [enhanced] sensory perception" (28-ASC).

In addition to having autism characteristics miscategorised by healthcare professionals, some participants thought clues that were indicative of ASC might have been missed. One autistic participant diagnosed with personality disorder reported:

"...autism runs so strongly in my family (all four children have AS/autism, and I think my father probably has Asperger Syndrome)." (175-ASC).

Likewise, a possibly autistic participant who was diagnosed with OCD reported:

"...I suspect that is really ASC, but it was the 80s and I am female. I have never been able to deal with much of anything in the morning, and apparently shoe tying before school was the last straw when little" (741-PASC).

These extracts highlight that the importance of family history and behavioural patterns in early childhood in making differential diagnosis between mental health conditions and ASC.

*Mental health difficulties perceived to be resultant of ASC.* The second most common reason for participants' disagreement with their mental health diagnoses was because they felt that their mental health conditions were resultant of the difficulties they experienced as part of living with ASC. These feelings were especially prevalent in participants who received depression and anxiety diagnoses (9 participants). One autistic participant explained that their depression stemmed from difficulties connecting with others:

“...because I did not ever really fit in socially and I couldn't understand what I was doing wrong, why people made friends but didn't include me, why I could never work out when to join in a conversation in a group situation etc, I was depressed because I thought I must be a very bad [unlovable] person. Now I know I definitely have Aspergers I understand why I don't often connect with others properly” (120-ASC).

Another autistic participant reported their depression and anxiety was a result of difficulties dealing with social demands.

“Depression and anxiety were a reaction to stress associated with having autistic spectrum difficulties. I am not anxious and depressed when I am in a **suitable** environment [emphasis added].” (468-ASC).

Daily living can be exhausting for autistic individuals, which could manifest as symptoms of depression. This was experienced by the following participant who disagreed with her depression diagnosis.

“...I live in a society that is not a suitable environment in which I can thrive, as I am autistic. It is hard to access accommodations. People are not kind and ask ignorant and hurtful questions, and make harmful assumptions when I plead with them to be accommodating as I am autistic. This is quite taxing, and I often feel very tired” (480-ASC).

An autistic participant felt that due to their autism not being understood, healthcare professionals tended to focus on the co-occurring mental health condition; a more useful treatment would be to address their psycho-social needs.



“...My underlying ASC is hard to explain [to] the GP in that I have expressed that I feel my depression is only a result of my, kind of, 'untreated Autism' in effect. Meaning, that if I can find help through relevant counselling, connecting with others, to accept and understand the autistic side of me and discover what my real needs are then I have a chance at learning a new vocabulary to express those needs and this will greatly reduce the resultant mental health issues that [recur], particularly depression” (178-ASC).

This kind of support, however, may be difficult to access; the second theme explores why this is the case.

**Clinical Barriers.** This theme describes the clinical barriers participants faced in seeking accurate diagnosis and support. These barriers were related to the participants' interactions and experiences with healthcare professionals, who they felt either:

“...didn't understand me” (1-ASC).

Or lacked an understanding of ASC:

“... [the] health professionals who diagnosed BPD aren't familiar enough with the symptoms of a female with AS... Now it feels like I've got a BPD diagnosis and they refuse to look at anything else” (196-ASC).

Other participants felt some healthcare professionals did not communicate with them. The following participants reported not having appropriate discussions regarding their diagnoses, and not being listened to, or given opportunities to raise concerns.

“I never had a proper assessment or discussion for my diagnosis of EUPD<sup>2</sup> and nobody told me, it just appeared on my medical records” (586-PASC).

“...I was misdiagnosed but no one would listen to me and I was told I was lying when I tried to explain” (2-ASC).

“...After obtaining medical notes, it is clear that my account of my experiences were being misunderstood and I was not given opportunities to clarify as information was withheld from me...” (8-ASC).

The consequence of a lack of autism awareness and communication was that it hindered participants receiving adequate support and having their needs met. The following autistic participants reported dissatisfaction with medication being the focus of their treatment:

“...I feel my GP is focusing purely on the depression and once he has a 'result' through the anti-depressants, then I will be deemed fully well again. Although I have taken the anti-depressants for 8 weeks now, I still struggle with dark thoughts, feelings of wanting to end it all and find life poses the same difficulties to me when it comes to functioning” (178-ASC).

“...my GP tries to keep throwing antidepressants at me but [I] think [I] just need to understand myself better [and] get other conditions diagnosed” (468-ASC).

Similarly, a possibly autistic participant talked about comparable experience with regards to therapeutic interventions received, with the focus on the treating the mental health condition overshadowing their undiagnosed autism.

“... I've had therapy with MIND<sup>3</sup> and [counselling] sessions, although they helped at the time, no one got to the bottom of what was wrong” (24-PASC).

The following participant's experience is a fitting illustration of this theme and the difficulties participants face in seeking accurate diagnosis and support. This participant was misdiagnosed with bipolar and prescribed various medications over many years to manage a condition they did not have.

“... I had a formal diagnosis of bipolar (II) condition for around 17 years. I actually satisfy the DSM criteria for this, but have only [ever] been hypomanic once and that was antidepressant induced. I don't benefit from mood stabilisers, antipsychotics or most antidepressants, and things like stress, working long days and staying up late don't induce mania. I have tried lots of different medications over the years, but for most of my [years] with a bipolar diagnosis, I worked in developing countries, didn't take any [psychotropic medications] and remained relatively mentally well... Hence, once my autism had been diagnosed, I was able to get a consultant psychiatrist to say that she didn't think I'd ever had bipolar and it has been revoked as a current diagnosis” (339-ASC).

## Discussion

The current study explored the experience of mental health diagnosis comparing non-autistic, autistic and possibly autistic people, and addressed the following research questions: 1) are autistic individuals more likely to report receiving mental health diagnosis/es and if so, what kind of diagnoses are they more likely to receive?; 2) are autistic individuals more likely to disagree with these diagnoses?; and 3) what were the reasons behind any disagreement? We found that autistic and possibly autistic adults reported receiving more mental health diagnoses compared to non-autistic adults. Specifically, significant differences were found for Depressive Disorders, Anxiety Disorders, Obsessive-Compulsive and Related Disorders, Trauma and Stress Related Disorders, Feeding and Eating Disorders, and Personality Disorders. Autistic and possibly autistic adults were also significantly less likely to agree with their mental health diagnoses than non-autistic adults. There were two major reasons for their disagreement: 1) ASC characteristics were confused with symptoms of a mental health condition; and 2) mental health difficulties perceived to be resultant of ASC. Autistic and possibly autistic individuals spoke about the clinical barriers that hinder accurate diagnosis and support, which include healthcare professionals' lack of awareness and understanding of autism, poor communication between autistic adults and healthcare professionals, and treatment not being suited to their needs.

Our findings are consistent with previous research documenting that autistic people (both diagnosed and undiagnosed) experience greater rates of co-occurring mental health conditions compared to the general population (Lever & Geurts, 2016). There may be several reasons as to why autistic people are more vulnerable to developing mental health conditions. For example, Haruvi-Lamdan et al. (2017) suggested that autistic people are more likely to experience stressful or traumatic life events such as being bullied or ostracised; cognitive features (e.g. having rigid thinking and rumination) may also affect how stressful events are processed; additionally, sensory sensitivities and sudden changes in routines and environment are a source of stress for autistic individuals over and above what is experienced by non-autistic individuals. Although the effect of these factors on autistic people's mental health is not yet fully understood, it seems clear that these are significant and widespread issues within the autistic population.

Our findings showed that only half of the participants in both the autistic (58.2%) and possibly autistic (45.5%) groups agreed with the mental health diagnosis/es they received, compared to over 86.5% in the non-autistic group. Qualitative responses from autistic and possibly autistic participants indicated that similarities in symptom presentation between ASC and a range of mental health conditions could be the source of these perceived misdiagnoses. Crane, Adams, Harper, Welch, and Pellicano (2018) conducted a survey and interviews exploring the mental health experience of young autistic people (16 -25 years). They found that young autistic people perceive themselves as different to non-autistic people in many domains (e.g. that they are more likely to feel under strain, or unhappy) even when they are not experiencing a mental health problem. This has implications for the development of diagnostic tools, because it could be the case that measures developed with the general population in mind may therefore fail to tease apart whether an autistic person is experiencing psychological distress that is over and above their typical behavioural presentation. One of the current research priorities of our group is to develop validated diagnostic tools to accurately assess mental health conditions in the autistic population (Cassidy, Bradley, Bowen, Wigham, & Rodgers, 2018ab).

Another contributing factor to the participants' perceived misdiagnosis was the lack of awareness and understanding of ASC amongst healthcare professionals. The current study highlights the importance of autism awareness training for health and social care professionals, as outlined by statutory guidance (Department of Health, March 2015). Such training would arm professionals with the confidence to communicate with, understand and support autistic people. Mental health professionals should be trained to understand the cognitive differences between autistic and neurotypical people, which will help them modify therapeutic interventions so they are effective for autistic people. In addition, more research is needed to test the effectiveness of modified therapeutic interventions and medications for various mental health conditions for the autistic population.

An important topic arose from our qualitative analysis relating to diagnostic overshadowing. Our participants reported that they felt healthcare professionals gave priority to treating mental health conditions, and thus leaving the underlying autism unaddressed and

other psycho-social needs unmet. Similarly, in the study by Crane et al. (2018), interviews with young autistic people highlighted numerous barriers for support. These included services not being tailored to their needs in relation to their autism, diagnostic and mental health services being “disjointed”, and worse, available support becoming even scarcer when they transitioned to adulthood. Given that many autistic adults received their diagnosis in adulthood, there is a real need to develop adequate post-diagnostic support systems. Post-diagnostic support could include psycho-social education and providing opportunities for autistic people to connect with others through local support network, advocacy services to support autistic people express their needs, and signposting to local resources. Mainstream services such as adult mental health services may also benefit from the support and consultation of a specialised ASC service in the local area (see NICE, 2014, for the Bristol Model).

### **Strengths and Limitations**

A key strength and novel aspect of the current study was the participatory approach, where autistic adults prioritised the study topic and questions utilised in the research. This ensured that the study was relevant, important and clear to autistic people, and thus more likely to be useful to their daily lives – a feature lacking in much previous autism research (Fletcher-Watson et al., 2018; Pellicano et al., 2014). Furthermore, we included possibly autistic people in the study who had not yet been formerly diagnosed, but strongly identified as autistic, as suggested by our autistic steering group. This inclusion allowed us to explore if yet to be diagnosed autistic adults shared similar experiences with those with a clinically confirmed diagnosis of ASC, which was important given many autistic adults remained undiagnosed, or receive a diagnosis much later in life (Lai & Baron-Cohen, 2015). Interestingly, the results from the confirmed and possibly autistic groups were very similar. The mean AQ score of the possibly autistic group (35.8) was well above the recommended cut-off (32+) for clinically significant level of autistic traits, and similar rates of mental health diagnoses and level of disagreement indicated shared experiences between these groups. However, we do acknowledge that there is no way of knowing if participants in the possibly

autistic group truly met the diagnostic criteria of ASC without a comprehensive clinical assessment.

We found lifetime rate of mental health and other diagnoses to be 88% for the autistic group and 52.5% for the non-autistic group. Previous work by Lever and Geurts (2016) reported similar lifetime rates of psychiatric conditions in their autistic sample (79%) and non-autistic group (48.8%). This shows that the self-reported rates of mental health diagnoses in our study are consistent with previously reported rates using standardised instruments for diagnosing mental health disorders. However, we are unable to verify whether the self-reported rates of disagreement consistent with actual rate of misdiagnosis due to the lack of previous research in this area. We are also unable to conclude whether autistic and possibly autistic individuals were more likely to disagree with *specific* mental health diagnoses that they received, because of the small sample size for the disagreement data, therefore these comparisons are likely to lack power and should be interpreted with caution (see Supplemental Materials B).

Finally, the self-selecting nature of our sample meant that it was not possible for us to control the variability in age and gender. How might these confounding variables have influenced our findings? Firstly, we might expect that participant groups with higher age to have a higher rate of lifetime mental health diagnosis, however, this was not the case; our autistic group reported significantly more lifetime mental health diagnoses despite being statistically younger than the non-autistic group. Secondly, we might expect that the participant group with greater proportion of females to have higher rates of lifetime mental health diagnosis based on findings previously reported for females, in particular for mood and anxiety disorders (Riecher-Rössler, 2016). This is again, not the case in our sample; our autistic group reported significantly higher rates of mental health diagnosis despite having a smaller proportion of females. While these confounding variables do not seem to have affected the findings in the predicted manner, we acknowledge that the confounding variables still pose a limitation to the study and may affect the generalisability of our findings.

### Footnote

<sup>1</sup>We use the term condition, rather than disorder, in recognition of the strengths and difficulties associated with autism, and in order to be less stigmatizing. Recent research has also found that the autistic community uses a range of terms to describe autism, but the term 'autistic person' is most preferred (Kenny et al., 2016). Thus, we use the terms ASC, autism and autistic synonymously throughout this article in recognition of this.

<sup>2</sup>The abbreviated terms for Borderline Personality Disorder (BPD) and Emotionally Unstable Personality Disorder (EUPD) were used interchangeably in participants' extract; these are synonyms for the same condition.

<sup>3</sup>Mind is a registered mental health charity and company that provides advice and support to anyone experiencing a mental health problem across England and Wales.

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**Conflict of interest**

The authors declare no conflict of interest.



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### Supplemental Materials A

#### Types of Personality Disorder

Out of those participants who reported a diagnosis of personality disorder, we further examined the type of personality disorders that participants were diagnosed with. Participants were asked to specify the specific subtype using a free text box if they selected “Personality Disorder” from the list of mental health conditions they were diagnosed with. Participants’ responses were coded under the DSM-V categories (see Table A). Of note, 7.7% of autistic group, and 5.6% of the possibly autistic group reported a diagnosis of Borderline Personality Disorder, compared to 2.1% in the non-autistic group; however, these differences were not statistically significant, Fisher’s Exact Test =5.15,  $p=.072$ ,  $V=.109$ .

Table A. Proportion of participants who reported personality disorder diagnoses.

Personality Disorder Types	Autistic		Possibly autistic		Non-autistic		Fisher’s Exact	$p$	$V$
Schizoid	1	(0.5%)	0	(0%)	0	(0%)	1.31	1.00	.049
Schizotypal	1	(0.5%)	1	(1.4%)	0	(0%)	2.09	.422	.069
Borderline	16	(7.7%)	4	(5.6%)	3	(2.1%)	5.24	.072	.109
Narcissistic	1	(0.5%)	0	(0%)	0	(0%)	1.31	1.00	.049
Avoidant	4	(1.9%)	0	(0%)	0	(0%)	2.79	.231	.099
Dependent	1	(0.5%)	0	(0%)	0	(0%)	1.31	1.00	.049
Obsessive-Compulsive	1	(0.5%)	1	(1.4%)	2	(1.4%)	1.49	.502	.048
Other	1	(0.5%)	0	(0%)	0	(0%)	1.31	1.00	.049

## Supplemental Materials B

### Disagreement with specific mental health diagnosis

To identify the number of participants who disagreed with specific mental health diagnoses, the mental health conditions explicitly mentioned in the comment box for the question “Please tell us what mental health diagnosis/es you disagree with, and why” are coded in their DSM-5 categories (see Table B). We compared the number of participants who disagreed with specific mental health diagnoses across groups. There were no significant between-group differences for any of the specific diagnosis categories (see Table B).

### Participants who disagree with multiple mental diagnoses

We compared the number of participants who disagreed with none, one, or two or more mental health diagnoses between the three groups (see Table B). There were significant differences in the number of mental health diagnoses participants disagreed with between groups, Fisher’s Exact Test = 13.0,  $p = .005$ . Post-hoc analysis involved pairwise comparisons using multiple Fisher’s exact tests (2 x 2) with a Bonferroni correction ( $p < .00556$ ). Two of the tests were significant; these were the 2 (non-autistic vs autistic) x 2 (None vs One Diagnosis) comparison ( $p = .004$ ) and the 2 (non-autistic vs possible autistic) x 2 (None vs One Diagnosis) comparison ( $p = .002$ ). These showed that there were higher proportions of participants in the autistic group and possibly autistic group who disagreed with one mental health diagnosis, compared to the non-autistic group, while the non-autistic group had greater proportions of participants who agreed with their mental health diagnosis compared to the other two groups. None of the other seven comparisons reached significance ( $p > .05$ ). No between-group differences were found in the number of participants who disagreed with two or more of their mental health diagnoses.

Table B. Number of participants who named specific mental health diagnosis they disagreed with.

	autistic		Possibly autistic		Non-autistic		Fisher's Exact	<i>p</i>	<i>V</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%			
Schizophrenia Spectrum and Other Psychotic Disorders	5	71.4% <sup>a</sup>	2	66.7% <sup>a</sup>	0	0% <sup>a</sup>	1.92	.682	.421
Bipolar and Related Disorders	5	41.7% <sup>a</sup>	3	60% <sup>a</sup>	1	50% <sup>a</sup>	.786	.800	.159
Depressive Disorders	8	5.0% <sup>a</sup>	5	9.6% <sup>a</sup>	1	1.7% <sup>a</sup>	3.39	.210	.115
Anxiety Disorders	3	2.0% <sup>a</sup>	1	2.2% <sup>a</sup>	1	2.1% <sup>a</sup>	.401	1.00	.005
Obsessive-Compulsive and Related Disorders	7	17.9% <sup>a</sup>	1	12.5% <sup>a</sup>	0	0% <sup>a</sup>	.355	1.00	.123
Trauma- and Stressor-Related Disorders	1	16.7% <sup>a</sup>	1	16.7% <sup>a</sup>	0	0% <sup>a</sup>	.930	1.00	.123
Feeding and Eating Disorders	5	23.8% <sup>a</sup>	1	12.5% <sup>a</sup>	0	0% <sup>a</sup>	.956	.676	.214
Personality Disorders	12	48% <sup>a</sup>	4	50% <sup>a</sup>	2	33.3% <sup>a</sup>	.553	.807	.111
Disagree with one mental health condition	31	16.9% <sup>b</sup>	13	22.8% <sup>b</sup>	3	4.1% <sup>b</sup>			
Disagree with two mental health condition	7	3.8% <sup>b</sup>	2	3.5% <sup>b</sup>	1	1.4% <sup>b</sup>			

Note. <sup>a</sup>Percentages are out of number of participants in each group who reported receiving specific mental health diagnosis (see in Table 3). <sup>b</sup>Percentages are out of number of participants in each group who reported receiving any mental health diagnosis.