

A New Model for Understanding and Treating Borderline Personality Disorder,
Revised Edition 2023. Heron Creek Press, NY
Lee Crandall Park, M.D. and Thomas J. Park, Ph.D.

Extended Abstract (8-10-2025)

There is a complexity about this subject that necessitates a rather lengthy Abstract.

There is strong evidence that **genetic factors** underlie or contribute to the development of severe mental disorders. **Borderline Personality Disorder (BPD)** is such a severe mental disorder, characterized by major dysfunctions of **Theory of Mind (ToM)**. BPD has a 1.6 to 5.9% estimated lifetime prevalence, and borderline features have been identified in over 9% of psychiatric outpatients and approximately 20% of psychiatric inpatients. It is currently understood to be a **Diathesis-Stress Disorder**, meaning that inherent genetic defects, limitations or predispositions engage with adverse childhood experiences to cause the disorder. We will argue, however, that **BPD is fully developmentally caused, with the genetic contribution being a normal "Risk Factor"** that is behaviorally exhibited by the very high sensitivity of pre-borderline children and borderline patients, and which is, paradoxically, not a flaw or a cause but instead is a **natural vulnerability of the uniquely Human Social Intelligence faculty for development of the Mind (ToM)**.

How could this seemingly preposterous theory be correct, that the remarkable neurobiological faculty for developing the human mind can also provide vulnerability to developing a severe mental disorder? Even Professor **Marsha Linehan**, the brilliant, empathic and religiously pious psychologist who developed Dialectical Behavior Therapy (DBT) for BPD, and who recently documented her own extensive history of severe BPD (*Building a Life Worth Living, A Memoir*, 2020), believes that she has a general "biological predisposition" to mental illness. She has never entertained even a possibility that, although **her exceptional sensitivity to the mental states of others and her empathic nature are very positive characteristics of enhanced Social Intelligence**, they also provided a natural vulnerability to developing a severe mental disorder in the setting of the **routine, well-intentioned psychological/emotional invalidation** that she had experienced from her beloved mother on an everyday basis throughout her childhood and adolescence.

There are two perfectly normal characteristics of the neurobiological Social Intelligence faculty for development of the mind that provide this vulnerability to faulty ToM development: (1) This faculty is Differentially Susceptible to the nature of the developmental social environment, such that the mind will develop collaboratively and normally in a healthy social environment but it will also **develop collaboratively and defectively in a sufficiently adverse social environment (the general p-factor)**. **(2) Inherent enhancement of this faculty** provides an increased potential for healthy development of the mind, but it also provides **exceptional vulnerability to developmental failure** in an adverse social environment.

We will argue that pre-borderline children are born with this enhanced Theory of Mind neurobiology, which provides a high genetic vulnerability for the occurrence of BPD when there is a specific adverse childhood Developmental Social Learning Environment (DSLE). Three considerations are at the basis for this argument. First, Borderline Personality Disorder is essentially a general disorder of the working mind, but the working mind does not even exist at birth. Instead, as is also the case with **language**, the mind is only an informationally empty neurobiological potential at birth that must be activated and gradually developed by means of a lengthy, interactive social learning engagement with other humans, progressing in development on an everyday basis throughout infancy, childhood, adolescence and early adulthood. The infant initially exhibits behaviors and vocal communications that are programmed for obtaining a secure base with caretakers, while also gradually developing language skills that accelerate the interpersonal learning experience leading to the mature ToM ability to correctly understand self and to correctly process and understand social information about the mental states of others. **In summary, the human working Mind, along with Language, must be entirely constructed by a very lengthy engagement in a post-birth Social Learning Experience**, and therefore it is critical to carefully examine this learning experience when researching mind and language development rather than to routinely assume that there must always be inherent neurological deficits. **Secondly, the well-documented Very High Sensitivity of all pre-borderline children and borderline patients to the social environment is the behavioral expression of an Enhanced Social Intelligence faculty for pursuing this learning experience.** This inherent enhancement involves an exceptionally vulnerable level of openness and trust (**Enhanced Epistemic Trust**) that would be a major learning asset in a normal, or especially in an enriched DSLE. However, this **very Differentially Susceptible** neurobiological enhancement provides **the same** exceptionally high level of Epistemic Trust and vulnerability when the sensitive pre-borderline “orchid” child begins to engage in this learning experience with an adverse DSLE.

Thirdly, whereas examination of childhood histories of borderline patients has revealed extensive reports of intermittent childhood physical/sexual abuse, **there has been minimal exploration of general levels of psychological/emotional support versus adversity/neglect in the routine DSLE, even though this Social Environment is the source for a child’s development of the mind**, and even though there have been numerous reports of such everyday adverse social environments in BPD, including Marsha Linehan’s memoir of her very painful, routine, adverse childhood social experiences.

We will argue that more careful research will fully confirm that the highly sensitive and exceptionally vulnerable pre-borderline child is born with an enhanced ToM potential, but experiences a routine, invalidating, psychological/emotional communicative mismatch with one or more caretakers, who are often in the role of trusted mentors. The invalidation can be somewhat subtle but persists on an everyday basis throughout the entire

developmental years, directly interfering with and severely perverting proper development of the child's enhanced Theory of Mind. **This gradually leads to BPD as a learned mental disorder presenting a predominant level of Epistemic Mistrust of others, and the severe, complex self/other psychopathologies that uniquely characterize BPD.** The adversity frequently involves caretakers who initially have good intentions but who are quite uninformed and/or misguided about how to understand and engage with a highly sensitive and vulnerable child whose enhanced Social Intelligence can include a wide range of highly autonomous feeling and thoughts. This can elicit negative responses by a parent who has rather strict opinions regarding correct ways of thinking, believing, and behaving (see Linehan's Memoir), and who persists in pressing for compliance. There can also be temperamental issues, such as a child's exuberance and adventurousness that engages with parental convictions about "proper" behaviors. Such a mismatch can result in degrees of parental overcontrol and irritability about the child's needy sensitivity and unexpected behaviors, involving a routine disapproval of and interference with the everyday expressed feelings and thoughts that are unfamiliar or alien to the parent's ways of thinking, thereby impeding rather than assisting in the natural development of ToM. This can also lead to an incorrect diagnosis of a disorder having inborn deficiencies, such as ADHD. The well-known antipathy held by many mental health professionals towards borderline patients continues this lifelong adverse social experience.

The co-presence in borderline patients of inherently enhanced, yet developmentally impaired ToM neurobiology provides for the complex and sometimes quite paradoxical symptomatology that uniquely identifies BPD, including the high sensitivity that has become developmentally entangled to become a major participant in the psychopathology, with the initially "enhanced" sensitivity becoming the dysfunctional "hyper" sensitivity. Patients may eagerly enter treatment, seeking resolution of their chronic attachment failures, but when they begin to experience the wished for closeness and vulnerability with the therapist this can resonate strongly with the enduring pain and sense of betrayal that has resulted from the history of never-ending child to parent attachment failures, thereby arousing increasing distrust of and hostility towards the therapist. This rather abrupt change, from a quite positive initial engagement to a very unpleasant negativity, has often disappointed and disturbed bewildered therapists, who begin to experience the sensitivity more as pathology and to believe they have been deceived. Further, although borderline patients demonstrate severe developmentally engendered impairments in mentalizing, trusting others, and understanding self and others, the inherent neurobiological enhancement for development of the mind remains, and they can sometimes, surprisingly, demonstrate good or even exceptional mentalization and social perceptivity (**Borderline Empathy Paradox**). Despite their severe condition this perceptivity has enabled some of them, especially (and paradoxically) those having greater symptomatic severity, to occasionally outmaneuver even experienced clinicians, drawing them into strong countertransferences and boundary violations that contribute to treatment failures. This confusing interpersonal power involving both

enhanced and defective ToM, is a key contributor to the stigma about BPD and its treatment.

The many years of theory and research focused on discovering inherently flawed neurobiological sources for BPD continues apace despite the persistent failures to confirm any flaws that are both inherent and causative, whereas research examining the everyday developmental social experience, which would necessitate exploration of parental routine ideas, affects and behaviors, is almost non-existent. This might be compared to focusing entirely on genetic vulnerabilities underlying signs of emaciation, while neglecting careful investigation of what has been actually happening in the person's daily life. A critical bias that interferes with correctly researching the mind and its development involves the fundamental problem that neither the patient's mind (ToM), nor what is occurring within it, can be directly examined by the preferred **Medical Methods**, but instead the mind of the patient must be "examined" by means of an interactive communicative engagement with the patient. This necessity for engaging in an appropriately genuine relationship of meaningful duration as a "research tool" has generally been neglected as unnecessary in psychiatric research.

Full confirmation that Borderline Personality Disorder is usually or almost always a fully developmentally engendered disorder of Theory of Mind would require New Research outlined in Section F. For instance, if neurobiological anomalies are confirmed in borderline patients, are they deficits or enhancements, and are they present at birth or do they only appear after the ToM learning experience commences post-birth? Regarding the high sensitivity characteristic, is vulnerability to parental approval/disapproval so great that even helpful corrections or suggestions can be experienced as rejection unless thoughtfully worded (See Suomi in text pp 63-68). **New research must focus on patients who have the high level of Severity identified in the discovery populations.** This is necessary because parenting is never perfect, such that we all experience a range of ToM flaws, leading from very mild imperfections, to "Borderline Spectrum Disorders", to BPD. Much research has lacked clarity about the severity of the condition, resulting in blurred and contradictory findings. (We believe that BPD is a disorder of severely developmentally flawed Social Intelligence, and that Autism is a disorder of severely inherently flawed Social Intelligence.) **With regard to Prevention, research must focus on gaining a clear understanding of the borderline patient's sensitivity characteristic and then developing guidelines for identifying and parenting highly sensitive children.** Studies that include direct engagement with parents and observation of their parenting characteristics would be of great help, but there continues to be a reluctance about directly examining parents and their parenting. With regard to **Treatment**, current models are very successful in resolving the acute general symptomatology. However, they persistently fail to satisfactorily resolve the self/other psychopathologies that are at the basis of the disorder, including particularly the painfully negative sense of self, the deep sense of emptiness, and the great difficulty developing trust about and enduring intimacy with others. **We believe that, whereas general support along with medication can successfully reduce the general symptomatology, only a genuine**

psychotherapeutic interpersonal relationship can adequately resolve these underlying disturbed ToM characteristics. With regard to the characteristics of the clinician/patient relationship, minimal research attention has been directed to examining the influence of the psychiatrist's routine verbal/emotional communications and behaviors, his/her personality characteristics such as capacity for warmth and empathy, degrees of narcissism, focus on or disinterest in the developmental social experience, availability for urgent contact, and length of sessions, as well as other therapist characteristics, as these factors may relate to treatment success or failure. This is despite the likelihood that the therapist/patient relationship interaction may well be the key to a sufficiently full and enduring recovery (just as the parent/child interaction is the key to developing the mental illness), and despite the remarkable findings by Whitehorn/Betz and others about the significance of the therapist/patient social interaction for patient recovery from mental illness as far back as the 1950's. With regard to **Psychiatric Residency Training Programs, there should always be a separate Psychotherapy Section that has at least equal status with other sections.** A key topic of research for this Section should be the therapist/patient relationship, particularly therapist personality and communicative characteristics that contribute to treatment successes or failures, as well as patient personality and behavioral characteristics that require specific therapist responses and cautions.

Necessary modifications to current treatment models for BPD are presented in Chapter 2. With regard to Psychotherapy, three modifications are presented in Chapter 2, Section B:

- (1) Learning from verbal interactions with the therapist.
- (2) Learning from behavioral interactions with the therapist.
- (3) Identification of undeveloped Social Intelligence potentials, including possible talents, and then learning how to make good use of them.

Full text is available at: leecrandallparkmd.net/BPDmonograph.

Available free as book by mail if requested to: lpark3@jhmi.edu. Also available online at ResearchGate.