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A New Model for Understanding and Treating Borderline Personality Disorder, Revised Edition 2023. Heron Creek Press, NY

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New Abstract: (7-26-2026)

Borderline Personality Disorder is a general disorder of Theory of Mind (ToM) that is fully developmentally engendered by a specific adverse childhood social environment.

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), the ability to know of and understand the mind of self and others. The severity, frequency and complexity of BPD presents serious problems for mental health services. It has a 1.4 to 2.7 estimated lifetime prevalence among adults in the U.S., and significant borderline features have been identified in 12% of psychiatric outpatients and approximately 22% of psychiatric inpatients.

Borderline Personality Disorder is currently understood to be a Diathesis-Stress Disorder, meaning that genetic defects, limitations or other inherent predispositions engage with adverse childhood experiences, particularly physical and sexual abuse, to cause the disorder. We agree that BPD results from inherent genetic factors engaging with adverse childhood experiences, but we argue that the genetic contribution is a perfectly normal "Risk Factor" rather than a defective contributor to the disorder, and that the key adverse experience for BPD is not abuse of the body but is instead persistent interference with development of the Mind, particularly Theory of Mind, that continues on an everyday basis throughout childhood.

Theory of Mind is a uniquely human Social Intelligence characteristic that is highly vulnerable to the nature of the social environment in which it develops. At birth Theory of Mind is just an informationally empty neurobiological potential, as is also the case of the neurobiological faculty for language development, and post-birth both faculties engage quite flexibly in a lengthy learning experience with the very complex human social environment to gradually reach full development by early adulthood. This developmental flexibility of Theory of Mind involves a

necessary inherent openness to and trust in the social learning environment (Epistemic Trust), but this openness and trust also provides a Differential Susceptibility to maldevelopment of the mind in an adverse learning environment. (The term, "Differential Susceptibility", refers to forms of life that are highly sensitive to the nature of the environment in which they develop, which aids them in developing collaboratively with an appropriate environment. However, this programmed collaboration can also lead to flawed development when it is occurring with an adverse or other inappropriate environment. Orchids are often cited as an example of differential susceptibility. The life story of Marsha Linehan, who developed cognitive behavior therapy for BPD, also demonstrates differential susceptibility. Her own very severe BPD developed during childhood in an everyday adverse social environment, and was followed by her gradual, full recovery and remarkable life success in subsequent psychotherapeutic and other healthy social environments.)

The higher is a child's inherent level of Theory of Mind neurobiology, the greater is this vulnerability to maldevelopment of Theory of Mind in an adverse learning environment. We argue and present evidence that (1): Pre-borderline children have this inherently enhanced Theory of Mind, which is exhibited by their very high awareness of and sensitivity to the social environment. This exceptional sensitivity is observed in all borderline patients, and we examine it extensively in the monograph. Sensitivity is generally considered to be a quite positive personal characteristic, and sensitive individuals can be quite vulnerable to criticism. (Current theory makes a contrary argument that the sensitivity of borderline patients involves inherently flawed neurobiology and therefore is evidence for the diathesis-stress model. This claim is made in the absence of any scientific confirmation as to whether the sensitivity could be a sign of a potential asset, a defect or plays no role at all in the occurrence of BPD.)

We argue (2): The highly sensitive pre-borderline child develops in a specific adverse social environment that involves a major mismatch of the caretaker's expectations and requirements with the sensitive child's developmental requirements. The parents are usually well-intentioned, but they have strong beliefs about how one should think, feel and behave, and they have not received, or have not accommodated to, guidance about making necessary parenting modifications for a very sensitive child. Instead, the unexpected and unwelcome

communications and behaviors of these children lead the parent to engage in persistent overcontrol, disapproval and invalidation of the highly vulnerable child's natural feelings and expressed thoughts. This can often be rather subtle, but it continues on an everyday basis throughout childhood, resulting in serious maldevelopment of Theory of Mind. In addition, the needy behaviors of these children present significant challenges that can lead to irritability and rejection. (Such behavioral challenges, as well as appropriate versus inappropriate responses to them, have been identified by Suomi in his studies of infant rhesus monkeys who also demonstrate enhanced social intelligence, challenging behaviors, and high vulnerability to the nature of their social environment: See text pp. 64-65.)

This new model of Borderline Personality Disorder is supported by the evidence and can explain the many puzzling features of the disorder, including the unique complexity of the symptomatology, the Borderline Empathy Paradox, the ability of borderline patients to entangle therapists into high discomfort and boundary violations, the timing of the rather abrupt appearance of an immediately severe disorder during the social challenges and requirements of adolescence, and the much better response of BPD to psychotherapy than to medical treatments.

With regard to the treatment of Borderline Personality Disorder, the general malfunctions of Theory of Mind, resulting entirely from developmental adversity, differentiate Borderline Personality Disorder very sharply from the other major mental disorders that have a diathesis-stress basis. Diathesis-Stress disorders have inherent neurobiological liabilities and therefore can respond well to medical treatments. However, if we are correct that Borderline Personality Disorder is a learned disorder of Theory of Mind, in the absence of such inherent liabilities, then medical treatments should have poor responses and psychotherapy should do well. This has clearly proven to be the case. Whereas drugs can provide some symptomatic improvement for BPD, only psychotherapy, in which one *Mind* actively engages with another *Mind,* can resolve the disturbed psychopathologies of the *Mind* that were engendered during the engagement of the child's *Mind* with adverse communications from the *Minds* of others. These psychopathologies include particularly the painfully negative sense of self, the profound feelings of emptiness, the deep distrust of others and the ever-failing relationships.

For psychotherapy to be successful the therapist must engage in an appropriately genuine relationship with the patient, which is absolutely necessary regardless of the countertransference risks it presents. In order to solve the complexity involved in psychotherapy with such challenging patients, there must be a major reinvigoration of psychotherapy research that has been long neglected, having been replaced with the over-medicalization of psychiatry. Secondly, there is also a great necessity to engage in parenting research in order to provide advice for parenting of highly sensitive children. Unfortunately, there continues to be a taboo not only about parenting research but about even bringing up the question whether flawed parenting could be a cause of a major mental illness. This taboo has left us to continue focusing almost entirely on finding evidence for an inherently flawed basis for BPD, such as incorrectly identifying the sensitivity characteristic as a sign of inherent neurobiological abnormality. We must move beyond this era of persistent taboo and proceed with new research that examines the influence of parenting on the development and maldevelopment of the mind. We must also educate researchers and the public about the urgent necessity to better understand the complexity of a child's learning how to understand self and others, while at the same time making clear that the goal of parenting research is to help parents to raise healthy minds, not to blame them or blame the child for the occurrence of a troubled mind.

This new model applies specifically to the severe disorder identified in the discovery populations rather than to the many spectrum populations that have also been examined.

ADDENDUM

What Borderline Personality Disorder IS:

Borderline Personality Disorder (BPD) is a major mental disorder, specifically "Theory of Mind Disorder". Since Theory of Mind deficiencies occur in all of us, the full title should be "Theory of Mind Spectrum Disorder", with this disorder being designated as at the highest severity level of the spectrum.

What Borderline Personality Disorder IS NOT. Borderline Personality Disorder is not a Personality Disorder. The DSM definition of a personality disorder would require that these patients initially have "borderline traits" that later becomes a mental disorder, just as Narcissist Personality Disorder" indicates that a person with "narcissist traits" subsequently develops a mental disorder. "Traits" are identified in DSM as "an enduring pattern of inner experience and

behavior that differs markedly from the expectations of the individual's culture''. This pattern endures over time, gradually leading to symptomatology and mental illness.

However, BPD does not occur in a person having a history of such complex, enduring, personality traits as described in the DSM. Instead, it appears rather abruptly during adolescence, in individuals having the "trait" of sensitivity. The way that BPD initially appears is entirely in line with other major mental disorders and not with personality disorders. This diagnosis error may have occurred because both Personality Disorders and Borderline Personality Disorder are characterized by Theory of Mind disturbances. However, in Personality Disorders these disturbances involve inborn deficiencies and therefore appear well before the development of clear symptomatology, whereas the Theory of Mind difficulties in BPD are developmentally engendered and therefore appear in association with the appearance of the symptomatology.

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