

1 **Effects of childhood maltreatment on social cognition and brain
2 functional connectivity in borderline personality disorder patients**

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32 **Abstract**

33 Borderline personality disorder (BPD) is a chronic condition characterized by high levels of
34 impulsivity, affective instability, and difficulty to establish and manage interpersonal relationships.
35 This paper assessed differences in performance on social cognitive paradigms (MASC, RMTE) and
36 how it related to child abuse. Specifically, it evaluated the relationship between performance on
37 cognitive paradigms and baseline brain connectivity in patients with BPD, compared to healthy
38 controls.

39 BPD patients had higher levels of childhood maltreatment, increased impulsivity and aggression, and
40 more dissociative symptoms than control subjects. For the sexual abuse subdimension, there were no
41 differences between the BPD and the control groups, but there was a negative correlation between
42 MASC scores and total childhood maltreatment levels, as well as between physical abuse, physical
43 negligence, and MASC. Both groups showed that the higher the level of childhood maltreatment, the
44 lower the performance on the MASC social cognitive test. Further, in the BPD group, there was
45 hypoconnectivity between the structures responsible for emotion regulation and social cognitive
46 responses that have been described as part of the frontolimbic circuitry. The more serious the child
47 abuse, the lower the connectivity.

48
49 Keywords: Borderline personality disorder, social cognition, functional connectivity, brain
50 remodeling, childhood maltreatment

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77 **1 Introduction**

78
79 Borderline personality disorder (BPD) is a chronic psychiatric condition characterized by high levels
80 of impulsivity and affective instability, as well as a marked difficulty to establish and manage
81 interpersonal relationships (1,2). In patients with this multifactorial disorder, a genetic vulnerability
82 has been identified (1,2). This vulnerability may interact with environmental factors such as lower
83 quality parental care (3,4) and a history of child abuse, which is present in a large number of research
84 subjects with BPD and has been proposed to be a contributing factor of the
85 disorder(5).

86
87 Chronic difficulties in interpersonal relationships are a BPD characteristic and have been studied
88 within the social cognition construct (6–8). With regard to performance in recognizing the emotions
89 of others, some studies have found higher levels of performance on tests among BPD patients,
90 including the reading the mind in the eyes test (RMTE) (9,10), while other studies have not reported
91 any differences in the ability to infer the mental states of self and others, compared to controls (11–
92 13). Still, other authors that have used ecological paradigms such as the Movie for the Assessment of
93 Social Cognition (MASC) have found a deficit in social cognition (7)

94
95 The neurobiological substrate of social cognition in BPD has been studied by task-related
96 neuroimaging studies such as the RMET paradigm and stimuli adaptations that test Theory of Mind
97 (ToM). These studies showed BPD patients have lower activation in areas within the temporal lobe,
98 the superior and medial frontal regions, the cingulate cortex, parietal cortex, hippocampus, and the
99 insula, as well as higher activation in bilateral amygdala, left temporal pole, medial frontal gyrus,
100 right middle and superior temporal gyrus, left precuneus, left middle occipital gyrus and right insula
101 compared to controls (10,14,15). In addition, a lower brain response has been reported in the BPD
102 group in the left superior temporal sulcus and gyrus in response to the modified version of the
103 Multifaceted Empathy Test (MET) (16). The functional connectivity describes the neuronal activity
104 correlation between different brain regions. Most studies describe correlations observed between
105 low-frequency fluctuations (<0.1 Hz) at basal state, which are organized in intrinsic neural networks
106 which are the same previously described in task-related research (17–19). One of these networks is
107 the default mode network (DMN), which shows a decreased connectivity in the precuneus, (14) and
108 the right posterior cingulate (20), as well as hyperconnectivity in the medial prefrontal cortex, the
109 anterior cingulate cortex, and the posterior precuneus/cingulate in BPD compare to healthy subjects
110 (21).

111
112 Most regions where differences were found in the brain function in BPD form part of the
113 frontolimbic circuit. Dysfunction of frontolimbic circuitry is one of the most accepted models to
114 explain the BPD symptoms, including emotional dysregulation and social cognition deficits (22).
115 This same circuit has been related to morphologic and functional brain changes associated with a
116 history of child abuse (23). Previous research showed gray matter volume reduction in orbitofrontal
117 cortex and temporal regions (24,25) and hyperactivation in response to affect-laden stimuli in the
118 right amygdala (26) related to childhood maltreatment as well as an effect in functional connectivity
119 (27,28).

120
121 Even though brain activation has been studied regarding social cognition tasks, the relationship
122 between functional connectivity at resting state and its association with the performance in such tasks

123 has not been explored. The inclusion of the childhood maltreatment variable may offer information
124 that could contribute to understanding the heterogeneity of clinical and neuroimaging results in BPD
125 studies (29). The primary goal of this paper was to assess differences compared to healthy controls in
126 the clinical performance of social cognitive paradigms and functional connectivity in resting state and
127 how it related to child maltreatment levels.
128

129 **2.-Materials and Methods**

130 For our study, we included 18 patients diagnosed with BPD and 15 controls without any psychiatric
131 diagnosis (CN) in a cross-sectional design. Both groups were matched by age and education. Due to
132 the higher prevalence of the psychiatric diagnosis among women, all study participants were women
133 (30) and right-handed. Participants were recruited from the outpatient clinic of the Institute for Social
134 Security and Services for State Workers (ISSSTE). We also recruited 4 participants from Instituto
135 Nacional de Psiquiatría “Ramón de la Fuente Muñiz” from an ongoing study (31). The protocol was
136 approved by the Ethics Committee of the ISSSTE (317.2017_P_2017) and the Ethics Committee of
137 the Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”. All the participants signed an
138 informed consent form, and the study followed the guidelines in the Declaration of Helsinki.

139 Patients diagnosed with BPD between 18 and 45 years old were included. The BPD diagnosis was
140 established by the attending psychiatrist and corroborated by a psychiatrist with experience in BPD,
141 who used the Diagnostic Interview for Borderline Revised (cut-off of 6)(32). To determine
142 comorbidity, we used the Spanish version of the Mini International Neuropsychiatric Interview
143 (MINI)(33). To obtain a representative sample of the clinical population, the study included patients
144 with Major depressive disorder (MDD), posttraumatic stress disorder comorbidity (PTSD) and the
145 use of medication. Exclusion criteria were disorder caused by use of addictive substances in the last
146 six months, bipolar disorder diagnosis, schizophrenia, obsessive-compulsive disorder, eating
147 disorders, and mental disability as described by the attending physician. For the control group,
148 psychopathologies were ruled out with the MINI. Diagnosis of Axis II disorders was ruled out by
149 means of SCID-II screening, and positives were evaluated by the psychiatrist.

150 We measured the social cognition construct using the Spanish version(34) of Movie for the
151 Assessment of Social Cognition (MASC)(35). This version is a 16-minute video depicting social
152 situations where the protagonists' emotions, thoughts, and social intentions are assessed through 46
153 multiple-choice questions. For each question, there is only one right answer. Mistakes were classified
154 as hyper-, hypo-, and lack of mentalization. The test has high inter-rater (ICC = 0.99) and test-retest
155 reliability ($r = 0.97$) and is highly consistent among observers (Cronbach's $\alpha = 0.86$) (35). The video
156 was provided by the author of the Spanish version (Guillermo Lahera; Universidad de Alcalá,
157 Madrid, Spain) and professionally dubbed into Mexican Spanish with an adaptation to the Mexican
158 accent and words. In addition, the study used the Reading the Mind in the Eyes test (RMTE) to
159 assess the ability to infer mental states with information from the eye gaze in pictures (36). Each
160 participant was asked to choose one of four descriptions of mental states for each picture. The Barratt
161 Impulsivity Scale (BIS-11), Buss-Perry Aggression Questionnaire (BPAQ) and Dissociative
162 Experiences Scale (DES) were applied. To determine whether there was a history of childhood
163 trauma, the Spanish version of the Childhood Trauma (self-administered) Questionnaire (CTQ) (37)
164 was used.

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167 **2.1 Magnetic resonance imaging**

168 Imaging data were obtained using a Phillips Ingenia 3 T with a 32-channel phased-array head coil.
169 We acquired structural and resting state functional (fMRI) sequences. For the resting-state fMRI
170 (rsfMRI), participants were instructed to remain quiet, keep their eyes open, without thinking of
171 anything in particular and were presented with a white cross on a black background. T2*-weighted
172 echo planar images were acquired with the following parameters: 36 axial slices, repetition time =
173 2000 ms, echo time = 30 ms, flip angle = 75°, field of view = 240 mm, slice thickness = 3.0 mm,
174 acquisition matrix = 80 x 80, and voxel size = 3.0 x 3.0 x 3.0 mm³. Structural T1-weighted images
175 were acquired with a repetition time = 7 ms, echo time = 3.5 ms, flip angle = 8°, field of view = 240
176 mm, slice thickness = 1.0 mm, acquisition matrix = 240 x 240, and voxel size = 1.0 x 1.0 x 1.0 mm³.
177

178 **2.2 Statistical analysis of clinical measures**

179
180 The statistical software SPSS-X version 22.0 for Windows, PC, was used for the analyses. We
181 visually inspected the clinical data and used the Shapiro-Wilks test to assess for normality. We first
182 compared the scores from the social cognition variables (MASC and RMTE), CTQ, BPAQ, BIS-11
183 and DES scale between the BPD and CN groups using a paired t-test (Mann-Whitney U test for non-
184 normal variables) with alpha of 0.05. We then performed Pearson's correlation between the MASC
185 and RMTE and CTQ scores to search for a possible relationship between childhood maltreatment and
186 social cognition. Finally, we created a new nominal variable using the MINI with the following
187 factors: BPD with depression (n = 11), BPD without depression (n = 7), and CN. Then we used a
188 one-way ANOVA to find differences in social cognition variables between the groups.
189

190 **2.3 Resting state functional connectivity preprocessing and analysis**

191
192 Data were preprocessed and analyzed using the CONN-fMRI Functional Connectivity toolbox (38).
193 The preprocessing pipeline prior to the analysis included: functional realignment and unwrap (subject
194 motion estimation and correction, functional center to (0,0,0) coordinates (translation), slice-timing
195 correction, detection of motion artifact sources with ART (Artifact Detection Tools; developed by
196 Stanford Medicine, Center for Interdisciplinary Brain Sciences Research) (Time points exceeding the
197 movement threshold of 2 mm or a global signal Z-value of 9 were defined as outliers), direct
198 segmentation and normalization (simultaneous Gray/White/CSF segmentation and normalization to
199 MNI space), and smoothing (5-mm FWHM Gaussian filter). With a general linear model, nuisance
200 variables were regressed out. The nuisance variables included were: subject motion parameters, raw
201 white matter, and cerebrospinal fluid signals. To correct for physiological noise, we used the
202 CompCor method (39). Signal time series were band-pass filtered between 0.008 and 0.09 Hz.
203

204 To assess baseline functional connectivity (rs-FC), we carried out a seed-based correlation analysis.
205 The seed regions were defined in CONN using an 8 mm kernel sphere (Figure 1). The definition of
206 the seeds was based on previous BPD results and regions associated with mentalization, especially
207 those in the DMN (10,14,15,21,40,41) (For details see Supplementary Material Table 1S). The
208 whole-brain individual correlation maps were computed with the average value of the BOLD signal
209 time course in resting state in each seed region, and correlation coefficients were estimated with the
210 BOLD signal time course for each voxel. A normal distribution of the resulting coefficients was
211 obtained with the Fisher transformation, and correlation maps (functional connectivity) were
212 obtained for each seed region and subject. The correlation maps for each seed were used to carry out
213 a second-level between-groups contrast GLM using age as a covariate. All contrasts were corrected
214 for multiple comparisons with the false discovery rate, with a p-threshold of 0.05 for each test and

215 cluster. Finally, we extracted the Z-maps (Fisher-transformed connectivity values) for each
216 significant cluster in each subject to perform Pearson correlation between functional connectivity and
217 clinical measures. Previous research indicated a higher likelihood of false positives resulting from
218 multiple comparisons. This was particularly the case of studies that correlated brain activation with
219 behavioral variable results. Thus, the study corrected for multiple comparisons (42,43).
220

221 **3.- Results**

222 **3.1 Clinical measures**

225 The psychiatric comorbidity and medications of the BPD group are summarized in Supplementary
226 Material Table 2S. Compared to the controls, BPD patients showed an increase in impulsivity,
227 aggression levels, and dissociative symptoms, and higher scores on the CTQ. Regarding abuse
228 subdimensions, there were no significant differences in sexual abuse between the groups (Table 1).
229 There was a negative correlation between MASC scores and total CTQ score; for the subdimensions,
230 there was a negative correlation between physical abuse, physical negligence, and total MASC, as
231 shown in Table 2.

232 In the BPD group, depression manifested in different ways. Depressed BPD subjects had lower
233 performance on the MASC ($M = 27.73$, $SD = 5.350$) and a decrease in the mean of -5.84 , 95% CI
234 $[-11.02, -.67]$ ($p = 0.026$), compared to non-depressed BPD subjects ($M = 33.57$, $SD = 3.15$), who
235 even performed better than the controls on the MASC ($M = 31.17$, $SD = 2.57$); the difference was,
236 however, not statistically significant ($p = 0.53$), as determined by one-way ANOVA for the three
237 groups, $F(2, 14.041) = 4.09$, $p < 0.040$. No significant differences in RMTE scoring were found
238 between the groups, $F(2, 30) = .479$, $p = 0.305$.
239

240 **3.2.-Functional connectivity**

241 Hypoconnectivity was found between limbic regions that play a role in emotional and affective
242 regulation and social responses in BPD patients. A hyperconnectivity was observed between the
243 medial prefrontal cortex and the left superior parietal lobe (Table 3 and Figure 2). There were no
244 statistically significant differences in the connectivity values between non-depressed and depressed
245 BPD subjects (Supplementary Material Table 2S).

246 **3.3 Correlation between clinical and functional connectivity**

247 We used Fisher-transformed connectivity values of the seven clusters identified with the comparative
248 analysis of the groups and correlated with the MASC, Movie for the Assessment of Social Cognition
249 (MASC), Reading the mind in the eyes (RMTE) and Childhood Trauma Questionnaire (CTQ) scores.
250 For the largest number of regions studied, a negative correlation was found between functional
251 connectivity and the total levels of child abuse, as well as some subdivisions of abuse as shown in
252 Table 4. That is, higher levels of child abuse are related to less connectivity in these regions (Figure
253 3).
254

255 **4.-Discussion**

256 We found that as the level of childhood maltreatment increased, the performance on the MASC
257 social cognitive test decreased in both the BPD and the control groups. In addition, there was
258 hypoconnectivity between structures associated with emotion regulation and social cognitive
259 responses in the BPD group. Connectivity decreased as levels of child abuse increased.
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262

263 Our findings relate to another study, where they showed that child abuse has an impact on the skills
264 necessary to develop stable and long-lasting interpersonal relationships(44). It has been well
265 established that the development of social cognition is linked to that of emotional and affective
266 communication through primary caregivers and an environment that is safe and free from excessive
267 stress-conditions that do not exist in the case of child abuse (45). Several studies have documented
268 that a disruption in the relationships between children and primary figures or extremely stressful
269 environments activate the hypothalamic-hypophyseal axis by releasing and activating several
270 mechanisms that have an effect on the brain (46,47). This physiological environment of extreme
271 stress interferes with the integration of mental representations during development, thus disrupting
272 the concepts of self and other and producing an unrealistic, unstable, and disproportionate
273 representation of the affection perceived and expressed (3). These circumstances arise in relational
274 contexts, a fact that accounts for BPD patients' clinical characteristics. These traits, in our study, may
275 have been expressed as changes in connectivity, aggression, impulsivity, and dissociative symptoms,
276 as compared to the control group.

277

278 We did not find differences between social cognitive tasks for both paradigms, which contrasts with
279 the ongoing controversy regarding a BPD patient's ability to read mental states (10,48). Data
280 collected with the MASC goes beyond the underlying process of recognizing emotion in social
281 interactions with information from the eye gaze that RMTE evaluates (36). It also includes an
282 assessment of the content of the mental state of the "other," based on contextual information and
283 elements that are not physically evident (49). This suggests that the instrument is ideal as it reflects
284 real-life situations. Nevertheless, the two paradigms evaluate the cognitive dimension of the social
285 cognitive process, and it is impossible to rule out the limitations of the affective dimension that are
286 associated with emotional regulation and the difficulties in distinguishing between self and the other
287 in BPD subjects (50). Our study showed that depression is associated with decreased social cognitive
288 performance. Although other research has found similar results (51), some authors have not found
289 differences between the BPD and the control groups and have surmised that rather than a state, social
290 cognition performance is a trait (52).

291

292 4.1 Functional Connectivity Results

293

294 Our results identified differences in the organization of brain activation patterns between the groups,
295 mainly hypoconnectivity between the regions explored in BPD. These regions are related to a broad
296 range of cognitive and emotional processes most of which play a role in social cognition. Besides, the
297 regions that we studied are a part or are related to the default mode network, which is activated by
298 processes that involve thought forms created by self as autobiographical memory, planning for the
299 future, and inferring one's mental states and those of "others" (53). Activity in the medial prefrontal
300 cortex (MPFC) is associated mainly with the ability to differentiate between self and the other, the
301 detection of one's own emotional state and the ability to mentalize (53,54). The temporal lobe has
302 been implicated in the processing of language and facial expressions, and it plays an essential role in
303 the process of inference of mental states (55,56). The anterior cingulate cortex (ACC) participates in
304 tasks of behavior monitoring, detection and prediction of error, decision making and processes
305 related to self-evaluation, especially in social contexts (57,58) in conjunction with the amygdala
306 which is a critical structure for the emotional regulation and has been studied extensively in BPD
307 (59–61). All these processes are essential for the success of interpersonal relations. The differences in
308 the connectivity of these structures may explain the impairment in differentiating between self and
309 others exhibited by the syndrome of identity diffusion that characterizes borderline personality
310 organization and could underlie primitive defense mechanisms such as splitting (62).

311

312 Some of the results in this study agree with previous task-based studies. The decrease of activity in
313 the temporal region can be found in previous studies(63,64). Regarding the amygdala, our findings
314 are in accordance with previous research (65), but evidence has been inconsistent (66). On the other
315 hand, studies have found a hyperactivation in MPFC and ACC (21,67) even though there are results
316 that show a hypoactivation of these structures at resting state (68,69) and task-based studies (14,65).
317 In this study, although there were differences in the brain connectivity in these regions with such an
318 importance for the social behavior, we did not observe a correlation with the clinical variables of
319 social cognition. The differences in the reading of the mental states in BPD are observed especially
320 under the effects of emotional stress (70,71). In that sense, we assume that the clinical performance in
321 social cognition tasks related to brain organization at rest could vary under intense emotional states.
322 Stress is associated with an abnormal pattern of deactivation of intrinsic neural networks(72,73),
323 which could be associated with variations in the performance of social skills. However, in this study,
324 it was not possible to show the effect of stress on brain organization.

325

326 Finally, we found an effect of childhood abuse on brain functional connectivity. The higher the level
327 of child abuse in the patients, the lower their brain connectivity. Although the effect of child
328 maltreatment on brain structures has been widely documented (27,74,75), the mechanism with which
329 child abuse might have an impact on organization and functional connectivity is still unclear. A
330 possible explanation is that child abuse is a factor associated with brain remodeling rather than a
331 harmful factor per se (29,76), especially with corticolimbic structures, as shown by a preclinical
332 study of adolescent rats (77). This “modeling” effect on brain organization is present especially
333 during critical stages and processes, such as pruning that is necessary for normal brain development
334 (78). In the first two years of life, a synaptic overproduction occurs in the brain, followed by
335 remodeling through pruning; these processes continue into adolescence (79). Although remodeling
336 occurs due to cellular programming, research has reported that pruning in this second phase is highly
337 sensitive to experience (80), including stress, because of the effect of inflammation mechanisms on
338 glial cells (81,82). This is consistent with the new paradigm that regards the brain as an active system
339 that self-organizes dynamically based on the information that it receives (83). This has been studied
340 in schizophrenic and autistic subjects, for whom dysfunctional pruning has been proposed (79,84).
341 Nonetheless, in BPD patients remodeling and differential pruning would be associated with stressful
342 childhood events or a lack of proper parenting. This proposition helps to understand BPD as the
343 result of maladaptive brain remodeling produced by the effect of traumatic experiences on brain
344 development.

345

346 **5.-Conclusion**

347

348 BPD patients endured more child abuse than the controls, which correlated with poorer performance
349 on the MASC social cognitive test and lower connectivity between structures involved in emotion
350 regulation and social cognitive responses, that are part of the frontolimbic circuitry. The rsfMRI
351 results provide information about internal baseline processed that seem altered in BPD patients. The
352 higher the level of child abuse in the patients, the lower their brain connectivity. We need to further
353 study these results, and there is a need to find if the introduction of safeguards to avoid abuse and
354 stress in such critical periods as are childhood and adolescence are beneficial, and patients may
355 recover from these harmful effects.

356

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364 **Ethics Statement**

365 This study was carried out in accordance with the recommendations of Ethics Committee, with
366 written informed consent from all subjects. All subjects gave written informed consent in accordance
367 with the Declaration of Helsinki. The protocol was approved by the Ethics Committee of both
368 institutions the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado y del
369 Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”.
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372 **Author Contributions**

373 XD, FP, and JG-O were involved in the design of the research protocol. XD, RA, and EG-V
374 contributed to acquisition and analysis of data; XD, FP, and EG-V drafted the manuscript, and all
375 authors contributed revising and approved it for publication
376

377 **Conflict of Interest Statement**

378 The authors declare that the research was conducted in the absence of any commercial or financial
379 relationships that could be a potential conflict of interest.
380

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646 **Tables and Figures**

Table 1. Demographic and clinical characteristics of BPD patients and healthy participants groups

	BPD (n= 18)	HC (n= 15)	p-value		
Age in years	31.17 \pm 9.52	32.80 \pm 8.65	p=.613 ^a		
Years in education	15.06 \pm 2.226	15.29 \pm 2.58	p=.790 ^a		
DES	30.28 \pm 19.93	9.94 \pm 7.63	p= .003 ^a		
BPAQ	91.25 \pm 20.95	72.08 \pm 19.85	p= .021 ^a		
BIS-11	63.50 \pm 14.09	50.15 \pm 15.50	p= .022 ^a		
CTQ TOTAL	59.06	18.63	38.87	8.50	p=.001 ^a
Emotional Abuse	16.56	5.31	9.53	2.41	p=.000 ^a
Emotional neglect	11.44	3.63	7.93	3.15	p=.006 ^a
Physical neglect	9.50	mdn	6.00	mdn	P=.006 ^b
Physical abuse	7.00	mdn	9.00	mdn	P=.059 ^b
Sexual abuse	9.00	mdn	5.00	mdn	p=.137 ^b
MASC total correct	30.00 \pm 5.3	31.03 \pm 2.58	p=.449 ^a		
Overmentalizing errors	6.00 \pm 2.89	5.23 \pm 2.7	p=.538 ^a		
“reduced ToM” errors	4.0	mdn	6.0	mdn	p=.686 ^b
“no ToM” errors	3	mdn	3	mdn	p=.714 ^b
RMTE	25.06 \pm 3.26	25.73 \pm 4.3	P=.614 ^a		

Data are presented in means \pm standard deviation unless otherwise specified. BPD, borderline personality disorder; HC, healthy controls; mdm, median; DES, Dissociative Experiences Scale; BPAQ, Buss-Perry Aggression Questionnaire; BIS-11, Barratt impulsiveness scale; CTQ, Childhood Trauma Questionnaire; MASC, Movie for the Assessment of Social Cognition; ToM, theory of mind; RMTE, Reading the mind in the eyes.

^a Two-sample two-tailed t-test.

^b Mann-Whitney U test.

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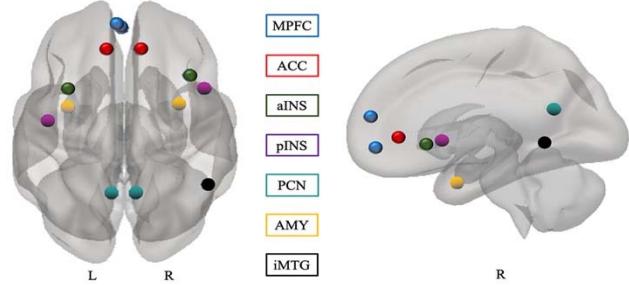
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660 **Figure 1.** Seeds used in this study.



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662 Fig 1. This figure shows the seeds; all seeds were defined based on previous BPD studies (see Table S1 in the Supplementary
663 Materials). MPFC, medial prefrontal cortex; ACC, anterior cingulate cortex; PCN, Precuneus; iMTG, inferior middle temporal gyrus;
664 AMY, amygdala; INS, insular cortex; L, left; R, right; a, anterior; p, posterior
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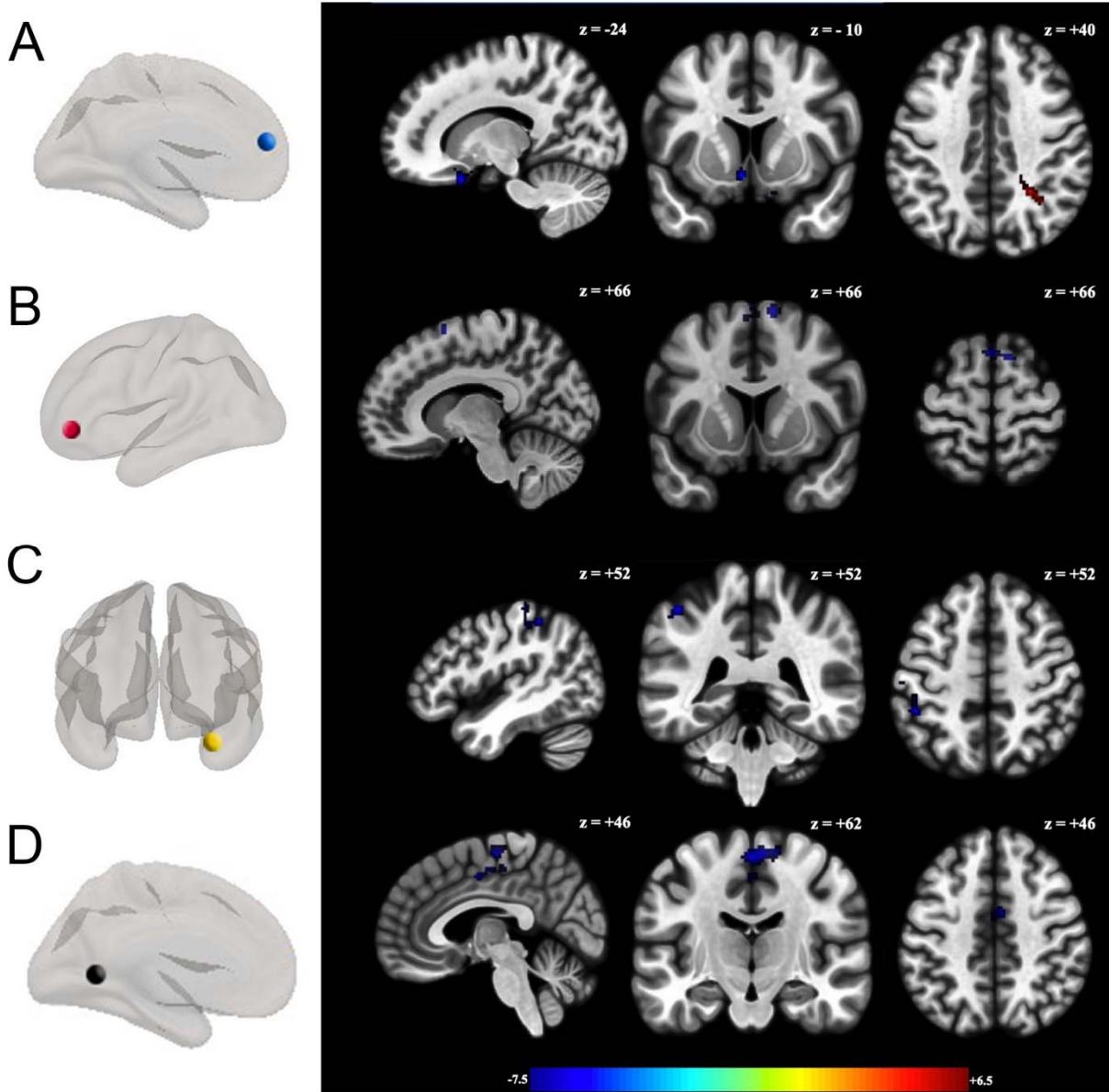
Table 2. Table of correlations between variables of social cognition and CTQ scores.

	1	2	3	4	5	6	7	8	9	10	11
1 MASC total correct	1										
2 MASC overmentalizing errors	-.02	1									
3 MASC “reduced ToM” errors	-.77 ^{**/++}	-.43 ^{*/++}	1								
4 MASC “no ToM” errors	-.50 ^{**/++}	-.40 ^{*/+}	.48 ^{**/++}	1							
5 RMTE	.35 ^{*/+}	.37 ^{*/+}	-.42 ^{*/++}	-.20	1						
6 CTQ_Total	-.38 ^{*/+}	-.04	.34 ^{*/+}	.09	-.15	1					
7 Physical neglect	-.38 ^{*/+}	-.05	.42 ^{*/++}	.03	-.23	.75 ^{**/++}	1				
8 Emotional Abuse	-.30	.13	.18	-.04	-.15	.86 ^{**/++}	.59 ^{**/++}	1			
9 Emotional neglect	-.24	-.34 ^{*/+}	.36 ^{*/+}	.19	-.29	.69 ^{**/++}	.62 ^{**/++}	.56 ^{**/++}	1		
10 Physical abuse	-.40 ^{*/+}	-.06	.37 ^{*/+}	.16	-.04	.88 ^{**/++}	.59 ^{**/++}	.74 ^{**/++}	.47 ^{**/++}	1	
11 Sexual abuse	-.18	.04	.12	.05	.02	.69 ^{**/++}	.31	.40 ^{**/+}	.22	.57 ^{**/++}	1
Mean	30.53	5.67	5.97	3.39	25.73	49.55	7.79	13.24	9.82	9.30	9.39
Standard Deviation (SD)	4.31	2.74	3.59	2.63	3.38	17.99	3.18	5.56	3.81	4.92	5.49

n = 33; **: p < 0.01 (bilateral); *: p < 0.05 (bilateral); +: FDR < 0.1; ++: FDR < 0.05; MASC, Movie for the Assessment of Social Cognition; ToM, theory of mind; RMTE, Reading the mind in the eyes; CTQ, Childhood Trauma Questionnaire.

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710 **Figure 2.** Seeds showing significant functional connectivity differences between groups
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713 Fig. 2. Seeds showing significant functional connectivity differences between groups with the (A) left medial prefrontal cortex, (B)
714 anterior cingulate cortex right; (C) right amygdala; and (D) inferior Middle temporal gyrus between BPD patients and healthy controls
715 controlling for age. All analyzed contrasts were corrected by multiple comparisons using the false discovery rate (FDR) at 0.05. Blue

716 and Orange/hot represent decreased and increased functional connectivity, respectively. The color bar indicates the *t*-value. Details of
 717 the clusters are shown in Table 3

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Table 3. Seeds showing significant functional connectivity differences between groups (BPD> CN) controlling for age

Seed	Regions	Peak voxel coordinate			Cluster size	β	t-scores	Cluster significance (FDR-corrected, threshold of p=0.05)	Connectivity	
		x	y	z						
MPFC_L	SPL_R	+26	-48	+40	61	0.21	6.05	0.0383	higher	
		NaC.L, SubCalC, P_L, Cd_L, OFC.L	-06	+10	-10	80	-0.17	-5.82	0.0213	lower
		OFC.R, SubCalC	+14	+16	-24	76	-0.19	-7.34	0.0213	lower
ACC_R	SFG_L, SFG_R	+10	+10	+66	110	-0.18	-5.42	0.0059	lower	
AMYG_R	SI_L, aSMG_L, SPG_L pSMG_L	-46	-40	+52	154	-0.16	-5.72	0.0010	lower	
iMTG-R	M1_R, M1_L, SMA_R, SMA_L	+00	-16	+62	180	-0.23	-4.62	0.0008	lower	
	SMA_R, M1_L, M1_L, M1_R, ACC	+04	-04	+46	131	-0.23	-4.66	0.0034	lower	

β , effect size (positive effects represent higher connectivity; negative effects represent lower connectivity); T, T-value; p-FDR, p corrected false discovery rate; L, left; R, right; a, anterior; p, posterior; i,inferior, s; superior ; **Seeds:** MPFC, medial pre-frontal cortex; ACC, anterior cingulate cortex; AMYG, amygdala; MTG Middle temporal gyrus. **Correlated areas:** Cd, Caudate; M1, precentral gyrus (primary motor cortex); NaC, Accumbens; OFC, Orbitofrontal cortex; P, Putamen; SI, Postcentral gyrus (primary somatosensory cortex); SFG, superior frontal gyrus; SubCalC, subcallosal cortex; SMG, supramarginal gyrus; SPL, superior parietal lobe; SMA, supplementary motor area. All analyzed contrasts were corrected by multiple comparisons using the false discovery rate (FDR) at 0.05.

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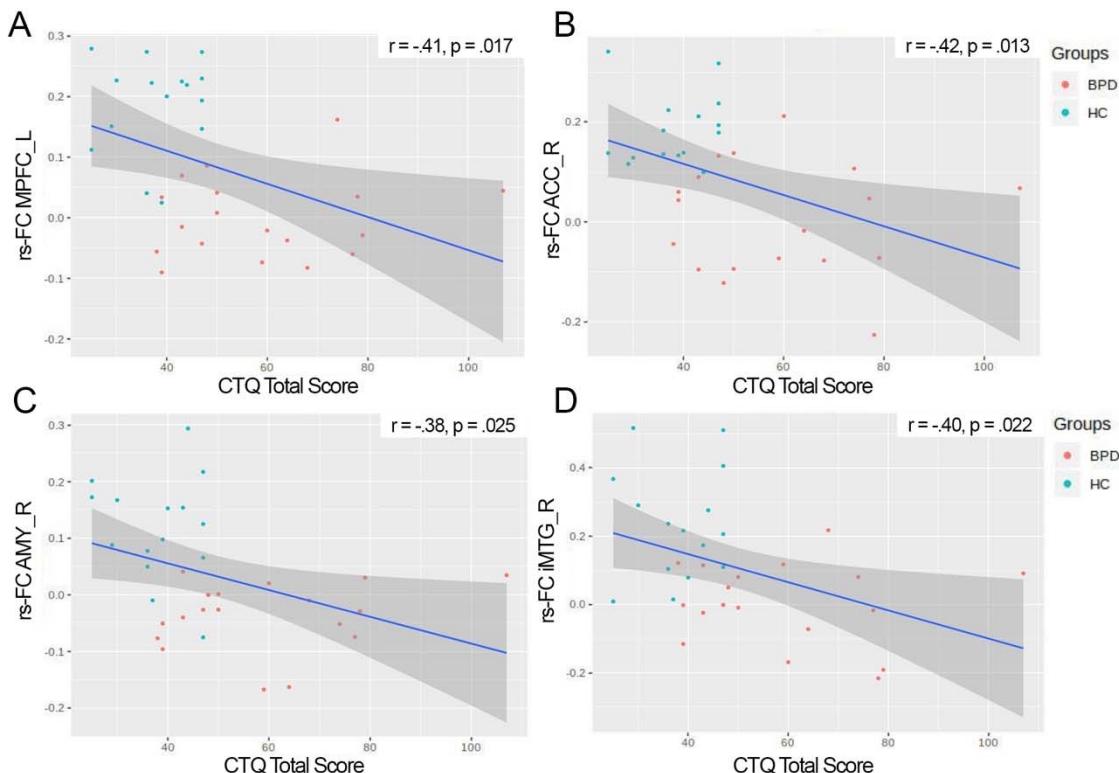
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737 **Figure 3.** Correlation between childhood trauma (total CTQ score) and functional connectivity.



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739 Fig 3 Correlation between childhood trauma (total CTQ score) and functional connectivity. The figure shows connectivity values for
740 seeds and cluster: (A) MPFC_L, left medial prefrontal cortex, cluster (x = +14, y = +16, z = -24); (B) ACC_R, right anterior cingulate
741 cortex, cluster (x = +10, y = +10, z = 66); (C) AMY_R, right amygdala, cluster (x = -46, y = -40, z = +52) and (D) iMTG_R, inferior
742 Middle temporal gyrus (x = +00, y = -16, z = +62). rs- = correlation coefficient. BPD = borderline personality disorder, HC = healthy
743 control.

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Table 4. Correlations between functional connectivity and clinical measures

Cluster MNI	MPFC_L	MPFC_L	MPFC_L	ACC_R	AMYG-R	iMTG-R	iMTG-R
Clinical Measures	+26 -48, +40	-06 +10 -10	+14 +16 -24	+10 +10 +66	-46 -40 +52	+00 -16 +62	+04 -04 +46
	r (p value)	r (p value)	r (p value)	r (p value)	r (p value)	r (p value)	r (p value)
MASC total correct	-0.135 (0.452)	0.220 (0.218)	0.201 (0.261)	0.355 (0.042)	-0.050 (0.779)	0.095 (0.597)	0.1263 (0.483)
Overmentalizing errors	0.011 (0.951)	-0.146 (0.414)	-0.139 (0.437)	-0.248 (0.164)	-0.210 (0.240)	-0.092 (0.607)	-0.048 (0.790)
“reduced ToM” errors	0.062 (0.729)	-0.068 (0.707)	-0.090 (0.617)	-0.130 (0.470)	0.139 (0.438)	0.030 (0.864)	0.030 (0.865)
“no ToM” errors	-0.072 (0.688)	-0.143 (0.426)	-0.181 (0.312)	-0.081 (0.652)	0.142 (0.430)	0.032 (0.856)	-0.161 (0.370)
RMTE	-0.362 (0.038)	0.212 (0.234)	0.272 (0.124)	0.242 (0.174)	0.031 (0.861)	-0.078 (0.663)	-0.064 (0.721)
CTQ TOTAL	0.443 (0.009)⁺	-0.248 (0.162)	-0.411(0.017)⁺	-0.427(0.013)⁺	-0.389 (0.025)	-0.409 (0.018)⁺	-0.395 (0.022)
Emotional Abuse	0.480 (0.004)⁺	-0.393 (0.023)	-0.431 0.012⁺	-0.503 (0.002)⁺	-0.495 (0.003)⁺	-0.508 (0.002)⁺	-0.483 (0.023)
Emotional neglect	0.309 (0.079)	-0.330 (0.060)	-0.471 (0.005⁺	-0.231 (0.194)	-0.288 (0.102)	-0.427 (0.013)⁺	-0.437 (0.004)⁺
Physical neglect	0.469 (0.005)⁺	-0.323 (0.066)	-0.426 (0.013)	-0.340 (0.052)	-0.291 (0.099)	-0.236 (0.186)	-0.176 (0.326)
Physical abuse	0.234 (0.188)	-0.142 (0.430)	-0.233 (0.191)	-0.335 (0.056)	-0.227 (0.203)	-0.211 (0.237)	-0.258 (0.145)
Sexual abuse	0.267 (0.132)	0.127 (0.480)	-0.127 (0.480)	-0.232 (0.193)	-0.199 (0.266)	-0.203 (0.256)	-0.168 (0.349)

MPFC, medial pre-frontal cortex; ACC, anterior cingulate cortex; AMYG, amygdala; MTG Middle temporal gyrus; Numbers represents: Pearson coefficient, p values; MASC, Movie for the Assessment of Social Cognition; ToM, theory of mind; RMTE, Reading the mind in the eyes; CTQ, Childhood Trauma Questionnaire. +: FDR < 0.1; No significant values were observed after FDR.05

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