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Extended Abstract (7-26-2026):

The complexity of Borderline Personality Disorder as a general disorder of Theory of Mind, fully engendered by an adverse developmental social learning environment, necessitates a more lengthy Abstract, especially considering that this model is radically new.

To begin, how could this seemingly preposterous theory be correct, that the neurobiological Social Intelligence faculty of Theory of Mind (ToM), the uniquely human ability to know of and to understand one's own mind and the minds of others, also provides a 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 (Guilford Press, 1993), and who recently documented her own history of severe BPD that persisted for several years during intensive treatment, believes that she has an inherent "biological predisposition" to developing mental illness (Building a Life Worth Living, A Memoir, 2020). Her strong attachment to her revered mother has prevented her from entertaining even a possibility that, instead of having inherently defective neurobiology, her exceptional sensitivity to the mental states of others and her empathic nature might have provided a natural vulnerability to the development of her mental disorder in the setting of the routine, even though well-intentioned, psychological/emotional invalidation that she had experienced from her beloved mother on an everyday basis throughout her childhood and adolescence. This invalidation involved strict guidance, which consisted of persistent disagreements with and corrections to Linehan's routine ways of thinking and feeling, thereby interfering with and seriously pathologizing the natural way her mind should have been developing.

Linehan's story about her Borderline Personality Disorder makes clear that her primary psychopathologies were Theory of Mind malfunctions, and it also makes clear that these malfunctions were connected to her mother's persistent interference with her natural ways of thinking and feeling. Could there nevertheless also have been some inherently flawed neurobiology playing a role in the

development of her mind and that would align with her diathesis-stress theory? The answer to this question must be considered in the context that a working human mind does not even exist at birth. Theory of Mind is only a neurobiological potential at birth that must develop by means of a lengthy a post-birth learning experience with the social environment. There are two perfectly normal characteristics of this Social Intelligence faculty that provide a natural vulnerability to maldevelopment during this learning experience: (1) IT IS A DEVELOPMENTALLY COLLABORATIVE FACULTY THAT IS "DIFFERENTIALLY SUSCEPTIBLE" TO THE NATURE OF THE DEVELOPMENTAL SOCIAL ENVIRONMENT, meaning that the mind will develop collaboratively and normally when there is a healthy social environment but this programmed collaboration will also result in defective development in a sufficiently adverse social environment (the GENERAL P-FACTOR). (2) When there is INHERENT ENHANCEMENT of this faculty there is increased potential for healthy development of the mind, but there is also exceptional vulnerability to developmental failure in an adverse social environment.

WE ARGUE THAT PATIENTS WITH BORDERLINE PERSONALTY DISORDER ARE BORN WITH THIS ENHANCED THEORY OF MIND NEUROBIOLOGY, WHICH PROVIDES A PARTICULARLY HIGH VULNERABILITY TO SERIOUS MALDEVELOPMENT WHEN THERE IS A SPECIFIC ADVERSE CHILDHOOD DEVELOPMENTAL SOCIAL LEARNING ENVIRONMENT (DSLE). THREE KEY CONSIDERATIONS ARE AT THE BASIS FOR THIS ARGUMENT. FIRST, REGARDING THE NATURE OF THE DISORDER, WE ARGUE THAT BORDERLINE PERSONALITY DISORDER IS A GENERAL DISORDER OF THEORY OF MIND. Borderline Personality Disorder is characterized by severe impairments in understanding self and others, which are the essential features of Theory of Mind. As is also the case with language, the mind is only an informationally empty neurobiological potential at birth, and both the mind and language must be activated and gradually developed by means of a very lengthy, interactive social learning engagement with other humans, progressing to full 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 for understanding Theory of Mind development and maldevelopment rather than continuing to routinely assume that there are always inherent neurological deficits underlying flawed ToM performance.

SECONDLY, REGARDING THE NATURE OF BORDERLINE PATIENTS, WE ARGUE THAT THEY ARE BORN WITH ENHANCED SOCIAL INTELLIGENCE, which has maldeveloped during childhood. Clinical evidence for this is their surprising ability, despite this maldevelopment, to confuse, outmaneuver and outwit therapists. Further, it is well-documented that pre-borderline children and borderline patients are "HIGHLY SENSITIVE", in that they are acutely alert to and reactive to the social environment. We argue that this is the behavioral expression of an enhanced Social Intelligence faculty for Theory of Mind. This involves an exceptionally high level of programmed openness to information about and from their mentors (Enhanced Epistemic Trust), which provides a major asset for flexible learning in a normal, and especially in an enriched DSLE. However, this very differentially susceptible enhancement also provides an exceptionally high vulnerability to maldevelopment when the highly sensitive pre-borderline "orchid" child engages in this learning experience with adverse DSLE. This high sensitivity characteristic is examined extensively in the text (see especially the remarkable research by Suomi: pp 56-57, 61-77), where we argue that it is a perfectly normal feature at birth, but it then becomes actively entangled as a dysfunctional active participant with an adversive developmental environment and therefore is mistakenly considered to be an inborn defective feature. If that were the case, there should be considerable evidence of parents seeking professional help for their troublesome, highly sensitive children at a quite early age. Instead, parents generally seek help for them as adolescents, after years of adverse influences on the development of the minds of these highly vulnerable children.

Why is the high sensitivity characteristic of borderline patients always designated as part of the psychopathology considering that sensitivity is generally believed to be a quite positive personality characteristic, and why don't we carefully research the parenting of highly sensitive children considering that parents carry such a key role in a child's mental development? We believe one of the answers to

this is that it is easier to place the source of a child's problems on the child, as Freud demonstrated, whereas there is a strong cultural taboo against examining a child's parenting despite how important this could be for discovering how to help parents raise mentally healthy children. Then there is the problem of "blaming" the patient as "treatment resistant" if a treatment doesn't work, rather examining possible problems with the treatment model or the treater.

THIRDLY, REGARDING THE SOURCE OF THE DISORDER, WE ARGUE THAT BORDERLINE PERSONALITY DISORDER IS FULLY DEVELOPMENTALLY ENGENDERED. Whereas examination of childhood histories of borderline patients has revealed reports of intermittent childhood physical/sexual abuse, there has been minimal research exploring degrees of interpersonal verbal/emotional support versus adversity/neglect in the routine, everyday Developmental Social Learning Environment, even though this social environment is the source for a child's development of the mind, and even though there have been reports of such everyday adverse social environments in BPD. We argue that more careful research will fully confirm our argument that the highly sensitive and exceptionally vulnerable pre-borderline child is born with enhanced ToM potential, but experiences a routine, invalidating, psychological/emotional communicative mismatch with one or more caretakers who are in the role of trusted mentors. The invalidation can be somewhat subtle, but it 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 to the complex self/other psychopathologies that uniquely characterize BPD, including the enhanced Social Intelligence abilities of these severely mentally ill patients to nevertheless confuse, outwit and interfere with the boundaries of therapists.

This developmental scenario is very clearly demonstrated in Linehan's memoir of her perfectly normal-appearing childhood years during which her thinking and feelings were being persistently misguided, followed by the quite abrupt appearance of a severe mental illness during the social challenges of adolescence, and leading to 2 years of continuous hospitalization for a persistently very disturbed patient, almost as if she became a different person. Following years of psychotherapy, medications, and especially certain special personal relationships, this highly sensitive woman became a

marvelously creative and famous professor of psychiatry at the University of Washington, clearly demonstrating enhanced Theory of Mind. It has been said that her life has been “almost a Kantian story of duty and transformation”.

The caretakers of pre-borderline children usually begin with good intentions, but are quite uninformed and/or misguided about how to understand and engage with a highly sensitive and vulnerable child, whose enhanced Social Intelligence includes a wide range of highly autonomous feeling and thoughts. Why would a parent invalidate a child’s mental development, and how are they doing it? This is particularly mysterious since the parents often appear to be genuinely concerned about and caring for their children. For instance, Linehan describes her mother as a very caring person even though she was constantly correcting her. We believe that there is a key mismatch between a parent who has very strong convictions and requirements about correct ways to think, feel and behave, and a needy, vulnerable, highly sensitive child with enhanced social intelligence who requires collaborative relationships in a clearly positive social environment, including permission and encouragement to freely experience, examine and learn from one’s own natural thoughts, feelings and behaviors. The child also experiences an urgency to gain clarity about the thoughts and feelings of the parents and others, rather than to simply rely on or comply with communications from others. These features can elicit increasingly negative responses by a parent who expects full compliance with authority, without resistance. There can also be temperamental issues such as a child’s spontaneity and adventurousness that engages with parental convictions about “proper” behaviors, leading to irritability about and even dislike of such a “bothersome” child. This persistent interference with and rejection of the child’s everyday expressions and behaviors that are unfamiliar or alien to the parent’s ways of thinking seriously impedes and pathologizes the development of the mind. The growing frustrations of a child subjected to this environment can lead the child to exhibit increasing resistance and additional behavioral issues. However, prior to adolescence such initially trusting children also try to resolve this parental misdirection by suppression of their natural perceptions about themselves and their parents, while even participating somewhat collaboratively in their own flawed Theory of Mind maldevelopment. This is followed by the rather abrupt appearance of a severe mental illness during the failure to resolve the major self/other social challenges of adolescence. The often surprising appearance of this severe disorder in adolescence, at times apparently out of the blue, can lead to an incorrect diagnosis of a disorder having inborn limitations such as ADHD. Unfortunately, this diagnosis is made in the ABSENCE

OF CAREFULLY EXAMINING THE PATIENT'S CHILDHOOD CARETAKING SOCIAL ENVIRONMENT.

The co-presence in borderline patients of inherently enhanced, yet developmentally impaired, Theory of Mind neurobiology provides for the complex and often quite paradoxical features that uniquely identify BPD, and which can bewilder and sometimes alienate therapists. This includes the initial "high" sensitivity that has become the dysfunctional "hyper" sensitivity. Patients may eagerly enter treatment seeking resolution for their chronic attachment failures, but when they begin to experience the wished for closeness with the therapist, the associated feelings of vulnerability can resonate strongly with the enduring pain and sense of betrayal that were engendered by the long history of never-ending child to parent attachment efforts and failures, often arousing distrust of and hostility towards the therapist. This rather abrupt change, from a quite positive initial engagement to an unpleasant negativity, has often disappointed and disturbed therapists who may then begin to experience the initially positive sensitivity as part of the pathology and to believe they may have been deliberately deceived. Further, although borderline patients demonstrate severe developmentally engendered impairments in mentalizing 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 a more severe disorder, to occasionally outmaneuver even experienced clinicians, drawing them into troublesome countertransferences and boundary violations that contribute to treatment failures. (Explanation: The higher is the inherent Social Intelligence, the higher is the vulnerability to adversity, leading to greater severity of the disorder.) This confusing interpersonal power, involving both enhanced and defective ToM, is a key contributor to the stigma about working with borderline patients.

This new understanding of Borderline Personality Disorder as a major mental illness rather than a personality disorder, and as a developmentally engendered disorder rather than a neurobiologically-based disorder can help to explain why we continue to fail in reaching an agreed upon understanding of BPD and how to treat it, why borderline patients can respond quite well to psychotherapy but quite poorly or not at all to pharmacotherapy, which is not the case of most major mental disorders, why patients so often fail to recover sufficiently when receiving current psychotherapies, why the findings

of clinical studies have at times been divergent or incompatible, why borderline patients can be so confused and yet simultaneously so interpersonally powerful, and why some psychiatrists are enraptured by these patients yet so many dislike and try to avoid treating them. Unfortunately theory and research continue to be fully focused on discovering inherently flawed neurobiological sources for BPD despite the persisting failure to confirm any flaws that are both inherent and causative, while research to examine the everyday developmental social experience, which would necessitate exploration of parental routine communications, affects and behaviors, is almost non-existent. This might be compared to focusing entirely on finding genetic vulnerabilities underlying signs of emaciation, while neglecting careful investigation of what has been actually happening in the person's daily life. This unconfirmed certainly that inherent genetic flaws always underlie such a major mental illness, and the failure to carefully investigate childhood social experiences, along with the general decrease of psychotherapy research and training, are contributing to concerns that Psychiatry could be losing its way.

CONCLUSIONS AND RECOMMENDATIONS FOR NEW RESEARCH ABOUT THE NATURE, PREVENTION AND TREATMENT OF BORDERLINE PERSONALITY DISORDER:

(1) NATURE OF BPD:

Full confirmation that Borderline Personality Disorder is a developmentally engendered disorder of Theory of Mind will require new research outlined in Chapter One, Section F. This research must focus specifically on patients who have the severe symptomatology that led to the discovery of Borderline Personality Disorder, as distinguished from the multitude of studies that have examined patients with mild to moderate symptomatology, or who have only borderline "features". Research must focus on these severely disturbed patients because Theory of Mind abilities and flaws exist in a spectrum. The mind develops during interactions with parents and others, and parenting is never perfect, such that all of us (100%) experience a range of ToM flaws, leading from minimal or mild imperfections to "Borderline Spectrum Disorders", to BPD as at the severest spectrum level. 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. Much research has lacked clarity about such spectrum disorders, resulting in blurred and contradictory findings.

Secondly, it is critical to examine childhood family interpersonal interactions and other social experiences. For instance, what happens when the expectations and requirements of a parent differ to a high degree from the natural communications and behaviors of the child, and what happens when the parent persistently insists that the child "corrects" these characteristics rather than to try to understand, reasonably work with, or even accommodate to these differences. Research is also necessary to determine whether neurobiological anomalies found in borderline patients are deficits, enhancements or neither, and whether they are present at birth or only appear after there has been a ToM learning experience. Regarding the high sensitivity characteristic, is the child's need for parental understanding and approval so great that even helpful corrections or suggestions can be experienced as rejection unless quite thoughtfully worded (See Suomi in text pp 63-67).

Considerable research about BPD has involved fixed a priori assumptions rather than the wisdom of ''Uncertainty', as elaborated by Whitehorn in his 1963 article "Education for "Uncertainty". Uncertainty is particularly necessary when contemplating BPD considering that it differs in such significant ways from other severe mental disorders. This issue is seen in the complete certainty that there are always genetic flaws underlying BPD despite the persisting absence of any truly confirmatory research. It is also seen in the certainty that the multitude of data identifying more females with BPD than males must involve flawed research. There is actually an easy explanation for this female majority if we are correct that the maldevelopment of the mind of borderline patients has resulted from flawed parenting. Which parent engages in the major parenting time with children? Babies of other primates are almost exclusively raised by their nurturing mothers. Human mothers are usually the major source for communication time with the developing minds of children during the early childhood years, especially considering the extensive time fathers typically spend working outside the home. This is not to simply say that more mothers than fathers contribute to the development of BPD, but that the development of BPD requires an everyday personal engagement by the parent with the child and that there is usually more mother-time available for this than father-time. Also the mother/daughter personal relationship is often a more intimate engagement than with boys, and therefore can be particularly influential in development of the working mind.

We have frequently wondered why, during all these years, there is almost never a suggestion that BPD could be fully developmentally engendered and that there should at least be research to rule this it in or out. This is all the more remarkable considering that

it has been fully acknowledged that both inherent and developmental factors are involved in the disorder, so why cannot we even imagine the alternative possibility that the developmental factor could be the primary or even the full cause rather than the inherent factor, something that even a high school student might imagine? We believe that there is an easy explanations for this that involves a Theory of Mind flaw of our own. Following the discovery of Thorazine we have been persistently educated in full confidence that serious mental illness must almost always be a medical illness. This is now believed in as strong a way as we believe the sun will rise every day, so questioning it never even comes to mind. This fixed belief of ours can remind us how easily the workings of the mind can be influenced by others. Of course our general ToM abilities do not become impaired by this one ToM limitation, whereas borderline patients suffer from serious impairment of basic workings of ToM itself.

Another critical bias that has interfered with correctly researching the mind's development and disorders involves the fundamental problem that neither the mind nor what is occurring within it can be directly examined by the preferred M**edical Methods.** Every mind develops in a specific family social environment, and no medical method can directly access either the ongoing activity of the mind or the everyday nature of the family interpersonal environment. Instead, these must be "examined" by means of interactive communicative engagements of the interviewer's mind with the patient's mind, and with family members and others. The necessity of engaging with a patient in an appropriately genuine relationship of meaningful duration as a "research tool" has generally been neglected as unnecessary for psychiatric research.

(2) PREVENTION: With regard to Prevention, it is most important to take into account the critical ways that BPD differs from other major mental disorders, particularly that BPD is fully engendered by an adversive developmental social environment in the absence of inherent defects. This means that prevention requires learning much more about routine interactions of the parents with their children, as well as about the nature and responses of sensitive children. This can then lead to effective guidelines for parenting of these children. However, such examination of parenting meets the realities of family research.

We had not fully realized how severe the taboo is against examining parenting as it may relate to mental illness until we asked two AI Chatbots (Microsoft Copilot and Google Gemini) the question: Can flawed parenting cause a mental illness? The shocking responses were that flawed parenting can contribute to mental illness but is NEVER the

actual cause of a mental illness. (Perhaps this AI response will improve over time.) This general taboo against "blaming" parents has mostly closed the door on such parenting research. The severity of the response is in alignment with our deep respect for family autonomy, and for the strong maternal instinct that is observed in mammals, requiring privacy without interference. However, instincts in humans tend to be somewhat diminished in general as compared to other mammals, and there are no signs at all of an instinct for knowing how to help a child to develop the very recently evolved human mind. If we do not carefully examine the influences of the daily parenting experience on development of the mind of a child are we as doctors the ones to "blame" for not learning how to provide necessary advice to parents, especially considering that flawed parenting primarily involves ignorance rather than willfulness? In our paper, "Giftedness and Psychological Abuse in Borderline Personality Disorder" (1992), the reports of intermittent physical and sexual abuse had led us to "blame" the parents for such abuse as being the source of BPD, but we now realize that the primary explanation for flawed parenting of pre-borderline children is not motivated abuse but is instead the absence of guidelines that can aid parents in resolving the challenges presented by highly sensitive children. Could we now be getting any closer to moving on beyond this taboo era considering that there may be growing awareness that current research is just continuing the never-ending failure to provide adequate guidance for young parents, most of whom are just beginners as mentors for children? It is essential that Universities develop the courage to fully, yet carefully and appropriately, study parenting as it influences the development of a child's mind, including adverse influences that can lead to maldevelopment of the mind and to mental illness. This can provide vital information not only for prevention of BPD and for its treatment, but for better understanding of mental disorders in general. We cannot simply wait for a Wizard of Oz who will magically provide a special brain for parents, an improved heart for therapists, and more "noive" for researchers. Discussion and controversy about guidance for a child's development of the mind can be found in the literature on Social-Emotional Learning (SEL).

(3) TREATMENT: With regard to treatment of Borderline Personality Disorder, medications can be helpful in reducing symptoms that result from the stresses of having a flawed mind. However, they cannot benefit the workings of the flawed mind itself, and so they fail to resolve the self/other psychopathologies that are at the basis of the disorder, including particularly the painfully negative sense of self, the profound feelings of emptiness, and the impossibility to develop

enduring trust in and intimacy with others, all of these contributing to recurring and chronic depression. The occurrence of this cluster of severe symptomatology appears to be unique to BPD. If they are present together in patients with other diagnoses it is most likely that those patients are borderline spectrum or fully borderline but misdiagnosed. Only psychotherapy can sufficiently resolve such malfunctioning workings of the mind that have been developmentally engendered. In order to engage directly with these workings of the patient's mind the therapist must accept the challenges involved in developing an appropriately genuine relationship with the patient while simultaneously carrying full responsibility for managing the correct nature of this personal engagement. This very necessary relationship can provide for a new Theory of Mind learning experience that is corrective for the flawed childhood Theory of Mind learning experience. When interacting with the borderline patient for this learning experience it is important for the therapist to anticipate that she/he will be highly alert to and wary about what might be going on in the therapist's mind. It is also very important to keep in mind that one is highly unlikely to learn about the private workings of the patient's mind without gaining and maintaining trust. Deep distrust of others is a core problem for borderline patients, and achieving and maintaining trust is critical for recovery. While the patient may initially appear friendly, needy, hopeful, appealing, loving, unfriendly, bothering, irritating, hostile, testing, etc., there is always the underlying urgent and profound need to trust the therapist, along with the learned and fearful distrust. It is therefore necessary to be prepared for rather sudden switches from an initially appealing collaboration and warmth to degrees of hostile distrust and verbal attacks. Nevertheless, it is best to begin the engagement rather pleasantly and congenially, much as you usually would do when introducing yourself to someone you usually would like to connect with, while also maintaining inner equanimity and anticipating likely surprising responses. This appropriately real you is much better than to appear clearly guarded, or to immediately engage with a formal treatment model, or too quickly bring up the topic of medication, all of which can suggest to the patient that there is going to be a repeat of childhood experiences of being told what is wrong with her/him rather than to simply inquire about her/his story with an open mind. We must also keep in mind that therapists cannot find out on their own what is going on in the patient's mind. Instead, the therapist must support the patient in examining the workings of her/his mind, and

then freely revealing and discussing them with the therapist. There must, of course, be some role-playing at the initial interview in order to immediately provide very clear signs of professional competence, composure, trustworthiness, congeniality and goodwill. The therapeutic significance of this initial contact is demonstrated clearly by the remarkable "placebo effect" that occurs during the initial interview in almost all drug studies, including our Nonblind Placebo Trial of 1965.

It is most unfortunate that so much theory and research about BPD and its treatment continues to be based on the unproven conviction that BPD is a medical condition that should respond to medical treatments, with the result there continues to be minimal interest in the likely critical of the clinician/patient relationship for improving the workings of the mind that has developed during the parent/child relationship. Our focus on the significance of the clinician/patient relationship is in alignment with the remarkable findings by Whitehorn and Betz about the importance of the therapist's routine ways of communicating for patient recovery from mental illness, even for Schizophrenia, as far back as the 1950's. Whitehorn said that when working with a disturbed mind you must contribute a piece of yourself to the engagement. It is critical to develop new studies that follow the Whitehorn/Betz model of carefully examining the communications of both the therapist and the patient as they engage together, particularly the "Interpersonal Stance" of the therapist, i.e., his/her routine "Way of Being" with the patient (APA Psychotherapy Caucus 2023), including ease of conversing, appropriate spontaneity, general positivity or negativity, capacity for warmth and empathy, comfortableness in providing personal information about oneself along with the wisdom to limit this to appropriate information, degree of narcissism, openness to learning versus overconfidence in one's own beliefs and biases, reliance on listening versus emphasis on advising, interest or absence of interest in the importance of prior life experiences, availability for urgent contact, length of sessions, as well as other therapist characteristics, as these factors may relate to treatment success or failure.

It is estimated that psychiatrists no longer have the time or financial means to provide such likely extensive psychotherapy (The Future of the Psychiatrist, Potash et. al., 2025). In no way does this mean that we should not perform the necessary research for understanding mental illness and for developing successful

treatments, simply because the findings might indicate a necessity for extensive psychotherapy. In fact, good research is most likely to significantly reduce the necessary length of psychotherapy for borderline patients.

Regarding Psychiatric Residency Training Programs, there should always be a separate Psychotherapy Section that carries, at the very least, a fully equal importance with the other sections. A key research topic for this Section should be the complexity of developing a genuine doctor/patient relationship that is also an appropriately professional engagement. This would include exploration of therapist communications and personality characteristics as they contribute to successes or failures in treating mental disorders, as well as patient characteristics that require specific therapist responses and cautions. (Findings of such research can also contribute to good selections of applicants for residency.)

Necessary modifications to current treatment models for BPD as a Learned Disorder 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. This includes cautious but careful exploration of the developmental social experience.
(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.