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The Interpersonal Hypersensitivity Formulation of Good Psychiatric Management as a Psychoeducational Intervention for Borderline Personality Disorder

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Abstract: Interpersonal hypersensitivity (IHS) is a core organizing concept of Good Psychiatric Management, a generalist treatment for borderline personality disorder (BPD) that relies on basic tools most clinicians already employ yet is informed by an organized and evidence-based framework, developed for dissemination in various mental health care settings. We work in an inpatient psychiatric unit that specializes in the management of suicidal crises at the University Hospitals of Geneva, Switzerland. Because we see numerous patients with previously undiagnosed BPD during their first hospitalization, we have developed techniques and instruments to promote efficient and easy-to-implement psychoeducation. In this article, we propose a practical and user-friendly measure of IHS that is well-suited for use by multidisciplinary inpatient staff or outpatient nursing-based staff, the IHS Ruler, which is based on a visual analog scale. It is a pragmatic tool for preliminary psychoeducation for patients with BPD and their caregivers. Its ease of use and structured way of presenting the inner experience of these patients in relation to their current interpersonal environment allows caregivers to establish a framework for internal reflection and sharing, discuss the causes of current transactions, and illuminate larger patterns in the causes of the patient's crises. Ultimately, this process can help patients and the clinical staff supporting them anticipate future problems.

Key Words: interpersonal hypersensitivity, borderline personality disorder, Good Psychiatric Management, psychoeducation, inpatient psychiatric unit

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All of the authors are involved in the teaching and dissemination of Good Psychiatric Management (GPM). The goal of this clinical research-oriented article is to improve the assessment and treatment of persons with psychiatric disabilities; no patient data were used in developing the article.

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INTRODUCTION to GUEST COLUMN

Eric M. Plakun, MD: The Austen Riggs Center, Stockbridge, MA; Founder and Past Leader, Psychotherapy Caucus, American Psychiatric Association, Washington, DC

Psychotherapy Section Editor

This issue's guest psychotherapy column focuses on the utilization of Good Psychiatric Management (GPM) in emergency departments. GPM is a "generalist" (ie, not provided by a specialist) treatment approach to patients with borderline personality disorder (BPD) that includes such significant psychodynamic elements as the interpersonal hypersensitivity formulation described by the authors. The accessibility of GPM to all kinds of clinicians is the major reason that I wanted to include this as a guest column, but there is another more personal reason. That is, GPM was developed by the late John Gunderson, whom I first came to admire in my residency days, when I read a paper co-authored by John elucidating what has become the contemporary view of BPD.[1] *That paper sparked my own decades of interest in the disorder.*

I recall conversations with John several years later about the need to develop broadly accessible guidance for clinicians to help them work with these challenging, often suicidal, but ubiquitous patients. He was a generous mentor and colleague who was always interested in helping younger clinicians find and develop their voices, and I was no exception. Based on those and other conversations about the need to increase the skills of those treating people with BPD, I developed ABIS, an Alliance-Based Intervention for Suicide, for use by psychodynamic clinicians struggling to establish and maintain a viable therapeutic alliance with suicidal borderline patients,[2,3] *while John developed the generalist approach of GPM.*[4]

John was a mentor to many besides me, including Lois Choi-Kain, who worked with John at the McLean Hospital Gunderson Residence and who is a co-author of this guest column. John, along with Lois and me, among others, recognized the importance of skills to treat BPD as a discrete and as a comorbid entity associated with treatment resistance, including at intermediate levels of care (eg, residential programs like the Austen Riggs Center or the Gunderson Residence). Intermediate levels of care may be indicated when patients lack the capacity to successfully use outpatient treatment to pursue recovery and a self-directed life. The inability to use outpatient treatment is often signaled when patients become mired in impasses or recurrent crises.

I and others miss John, his keen mind, and his generous mentorship. In closing, I thought I would share a personal recollection of a moment when I was able to return the favor of mentorship to John in a small way.

In 2000, John and I were both presenting at a conference in Paris—not so far from Geneva, where the lead authors of

this guest column do their work. At the end of the first day of the meetings, as I was walking to the Metro to return to my hotel, I spotted John standing on the curb of a busy boulevard, desperately and unsuccessfully trying to flag down a taxi at the height of the frenetic Paris rush hour. When I approached him, I learned that John understood scarcely a word of French. He was relying on a piece of paper he hoped to give to a taxi driver that had the hotel's address written on it. Since getting a taxi seemed hopeless, and it emerged that we were staying at the same small hotel, John accepted my invitation to mentor him in using the Paris Metro. I am so pleased that I was able to return the favor in a small way by serving as a Paris Metro mentor for John, who offered mentorship to so many of us along our own journeys. May John's memory be a blessing to those who knew him.

Interpersonal hypersensitivity (IHS) is a construct that explains the shifting phenomenology of borderline personality disorder (BPD) and informs interventions for BPD.[5,6] Gunderson initially developed IHS as a psychodynamically informed case formulation that presents a means of understanding why the seemingly disparate characteristics of patients with BPD cluster together and why they shift in a certain sequence. Ego-regression phenomena, now known as social-cognitive dysfunction, were seen as a key mechanism of oscillating symptomatic states, destabilized and restored by events in a patient's major interpersonal relationships.[7]

Today IHS is a core organizing concept of Good Psychiatric Management (GPM), a generalist treatment for BPD that relies on basic tools most clinicians already employ. GPM is informed by an evidence-based framework, developed for dissemination in various mental health care settings.[4,8] IHS combines a basic formulation of BPD with a construct that pragmatically incorporates common factors from prevailing evidence-based therapeutic models. For example, GPM integrates emotion regulation and interpersonal effectiveness from dialectical behavior therapy, the curious not-knowing stance and thinking before reacting from mentalization-based therapy, and the discussion of anger and unconscious motives from transference-focused psychotherapy, as well as contemporary social-cognitive empirical findings regarding rejection sensitivity and disturbed social cognition.[9–11] GPM provides an explanatory framework that links major BPD effects—depression, anxiety, anger, dissociation, and despair—to interpersonal functioning.[12] Initially developed for BPD, GPM's way of organizing the internal coherence of polymorphous mental health conditions into reactive symptomatology dependent on environmental context has recently been extended to other prevalent personality disorders such as narcissistic personality disorder[13,14] and obsessive-compulsive personality disorder.[15] It also fits well into the increasingly favored DSM-5 Alternative Model for Personality Disorders, which includes interpersonal dysfunction as a key component of personality disorders, not just a functional and distal impairment consequent to the severity of highly maladaptive traits.[16,17]

Within the 4 identified BPD domains (affects, identity, behaviors, and interpersonal relationships), the disturbed relationship aspect has been the most central to clinical formulations of not only BPD but also personality disorders more broadly.[6,18–22] The interpersonal dynamics incorporated into GPM's IHS formulation tie together longstanding psychodynamic thinking, concepts from attachment research, and descriptions of observable psychiatric symptoms. This multilevel concept of IHS is most evident in clinical situations, where stakeholders (including patients, caregivers, supervisees, and supervisors) can identify and examine modifiable social transactions related to the relational difficulties faced by patients with BPD. IHS is an essential foundation of GPM-informed supervision, with encouragement given to supervisees to forego open-ended explanations for stressors and instead actively ferret out interpersonal stressors.[8]

INTERVENTION

We work as mental health practitioners and serve as medical staff and supervisors in an inpatient psychiatric unit that specializes in the management of suicidal crises at the University Hospitals of Geneva, Switzerland. In brief, intensive 7-day admissions, we provide care for people in crisis with suicidal thoughts or actions. People with BPD are overrepresented among our patients,[23] much as they are in other clinical settings internationally,[24] since the hospital is frequently an inevitable waystation in the trajectory of BPD care. When we assumed clinical responsibility for our unit several years ago, we wished to inform our practice in line with advances in contemporary treatments. We use an admixture of mentalization-based therapy, a major empirically validated specialist therapy for BPD,[25] and GPM,[26] since they have a great deal in common. The shared points of convergence include an ethic of optimizing treatment accessibility, an attitude of flexibility in implementation, and an insistence on openly discussing the BPD diagnosis and providing psychoeducation.[27] Since we see numerous patients during their first hospitalization who are not yet diagnosed with BPD, we worked to develop techniques and tools to promote efficient and easy-to-implement psychoeducation. For this purpose, we propose extending the use of IHS from its explanatory and treatment-information base to make it a primary BPD psychoeducational device. We do this by producing practical and user-friendly adaptations of IHS that are well-suited for use by multidisciplinary inpatient staff or outpatient nursing-based staff. It is well known that psychoeducation is an essential prerequisite for engaging patients with BPD in their treatment that can itself reduce symptom severity, especially in the early stages of treatment, even in the form of a single workshop provided by a nondoctoral level staff member.[28,29] It is particularly important to enlist the nursing profession to work in a way that is specifically tailored to BPD. A lack of training and education among these team members, more than among other mental health practitioners, has the potential to contribute to high burnout, stigma, and misinformed care because nursing staff stand at the forefront of care for these patients in emergency rooms and inpatient psychiatric units.[30] In this article, we first describe the way in which we introduce and use IHS with our patients with BPD and with newly arrived staff on the ward. We then present a psychoeducational tool, the IHS Ruler, which is based on a visual rating scale. We would like to point out that formal GPM training (eg, a 1-day online course) is not a mandatory prerequisite for using these tools, but that a minimal introduction to GPM is useful to understand and speak the straightforward common language that GPM derives from the larger BPD field. In our experience, GPM is particularly well suited for compact, brief, repeated on-site teaching formats for multidisciplinary teams from various backgrounds and with a high rotation rate. All the material

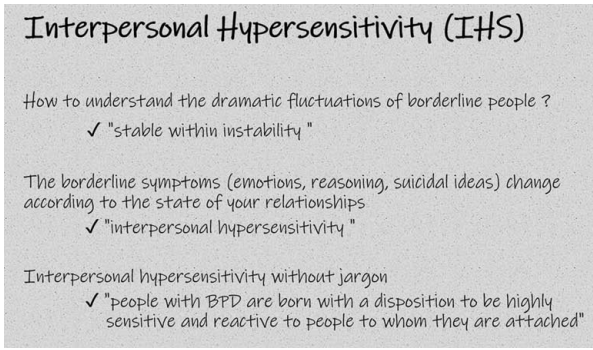

FIGURE 1. Interpersonal hypersensitivity as introduced to patients with BPD and their caregivers. BPD indicates borderline personality disorder.

presented in this article was translated from French to English.

IHS AS A PSYCHOEDUCATIONAL TOOL

Introducing IHS to Patients With BPD and Their Caregivers

GPM's IHS model focuses on the interpersonal nature of patients' key instabilities and fluctuations, thereby tracing a map for both patients with BPD and caregivers of how recurrent crisis situations unfold. What makes the IHS model particularly accessible is that it allows caregivers to understand the interpersonal crisis in more multidimensional terms than the mere presence of symptoms or traits. Above all, it facilitates awareness of the less obvious internal psychological process experienced by the person in crisis. It can easily be taught even to distressed patients, who can use it to ground their experiences in a basic understanding that mobilizes their resources to attain stability in a crisis by strengthening cognitive clarity and control. Figure 1 is an example of a graphic that we use to introduce the IHS concept to our patients with BPD and newly arrived nurses, utilizing clear and understandable language for nontherapist staff and patients in high states of arousal.

IHS—From Attachment to Intervention

We generally illustrate the whole cascade of how IHS determines symptomatic fluctuations in BPD by introducing the 4 discrete IHS states shown in Figure 2 and beginning a narrative concerning the progression between states.

Attachment Roots

IHS has its roots in attachment theories.[6] The 4 different interpersonal states shown in Figure 2 contextualize the varying symptomatic profiles that those with BPD experience. Each state consists of a multifaceted package that involves BPD-related ways of feeling, hypervigilance to signals conveyed by others, bids to induce others to react, and efforts to restore security in those relationships. We conceive of attachment in 2 ways. The first is in a traditional sense as an archaic human survival technique[31,32] that organizes around a belief that you will not survive if you cannot attach yourself properly. The insecure and disorganizing attachment style associated with BPD drives tendencies to evoke reactions as proof of care rather than empathically related efforts made in more sustainable and mutual ways.[6] Centralizing this attachment-based concept of the BPD mode of IHS, GPM's model explains the intensity and speed of the minute-by-minute shifts our patients experience. We also see attachment in a second way, as a much more flexible disposition than initially thought.[33] This viewpoint regards attachment as a disposition that enlists both the subject attached and its figures of attachment in a reciprocal shaping,[6,34] hence, our conceptualization of the bundle-quality related to attachment states as described above: parents shape their children, but children also shape their parents, as do patients and caregivers. Longitudinal research has demonstrated that BPD symptoms such as emotional dysregulation and impulsivity predict diminished parental warmth, increased parental punishment, and social adversities with peers such as bullying.[35,36] Using this formulation, clinicians and patients can collaborate both to validate why people with BPD act in this way and, with sufficient effort, to transform these tendencies to be more modulated, realistic, and effective in adult relationships.

Connected/Attached State

In the first state, the connected/attached state, the person feels contained by the relationship, confident, and calm, although chronically anxious about the status of caregiving relationships. Ingratiating, suggestible, and compliant behaviors dominate the patient's presentation. Caregivers relish this state in therapy: "It's a pleasure to work with him, I don't really know why the other therapist had a problem." Patients respond in kind: "You are the best therapist I ever met, I will recommend you to all my friends." Or families remember: "He could be so lovable and pleasant." However, fears of losing the relationship and rejection lead to a hypervigilance toward any real or perceived threat to this sole good relationship. This vigilance can, in turn, induce distortions and cause harmless signs or behaviors to appear as threats to the relationship since splitting or all-good/all-bad thinking reigns. Thus, it is not a "normal" or "secure" attachment state owing to the fact that it is infiltrated by a fragile idealized dependency on others who are bound to fail.

Threatened State

Inevitably at some point, perceived threats emerge in this totally positive relationship (eg, the therapist looking at her watch). Interpersonal stress is mediated by 2 well-documented factors in the social-cognitive literature on BPD, namely rejection sensitivity and cognitive distortions.[9–11] Rejection sensitivity implies a low detection threshold (eg, the patient with BPD notices that the caregiver looks at her watch).

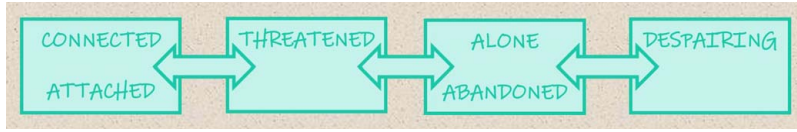

FIGURE 2. Attachment states.

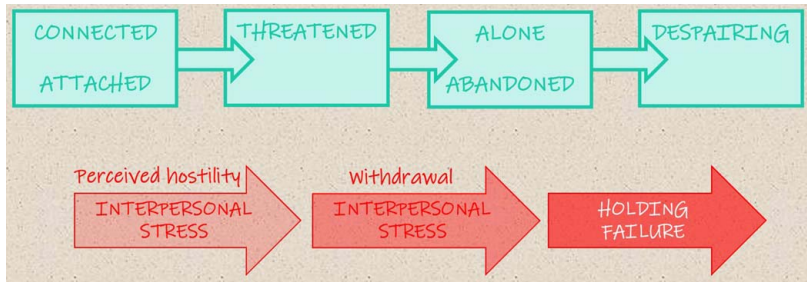

FIGURE 3. Interpersonal stressors.

Cognitive distortions, driven by failures of frontolimbic modulation of arousal, contribute to a bias (eg, patients with BPD say to themselves that the therapist is looking at her watch not because it forms part of the organization of the therapist's schedule, but because the therapist does not care about the patient as much as the patient imagined).

The second state, the threatened state, is what has conferred on BPD a form of notoriety that contributes to stigma and aversion toward this help-seeking patient population. Patients with BPD will devalue you and then insult you after you have looked at your watch, or they will speak less and less, leading the therapist to seriously worry about the possibility of a potential nonsuicidal self-injury or suicidal threat by the end of the session. Normally, when those without BPD feel threatened in a relationship, they adequately activate their attachment system with effective behavioral bids, and significant others willingly come to their aid. In patients with BPD, by contrast, the opposite occurs. They inadequately activate their attachment system by inciting fear or anger that manifests itself so urgently that it demands reaction without reflection and increases the risk of real rejection. Clinically, the threatened state is the core of the borderline paradox because patients with BPD would so much like to be brought back to the connected state, but they do exactly what inevitably makes it difficult for others to stay connected.

At the same time, it is in the threatened state that intervention by caregivers can be the most likely to promote change because it is a state in which patients are still attentive to cues and responses from caregivers and remain invested in listening to them. If the interlocutors see this state as the very symptomatic state for which the patient needs help, they can remain actively connected and deal with the threat at hand in a way that allows the collaborative therapeutic relationship to be maintained. For example, when a patient starts yelling at the care provider or therapist, the intuitive movement is to become silent or take a break from the patient. GPM teaches a counterintuitive movement, namely that of coming forward and saying: "You're yelling at me, but I don't think you want me to leave—I think it is important that I stay. I will stay because our work is to gain a better understanding with you of what is happening now, what your needs are, and how we can find a way to cope better." That also provides a fairly elegant definition of patients with BPD, who are regarded as "people with special needs who are difficult to meet intuitively."

Alone/Abandoned State

If real rejection occurs (and not only fear of rejection), patients with BPD then pass into the alone/abandoned state, marked by dissociation because the mental pain is too severe, paranoid thinking, and cognitive regression because it is always better to be persecuted by a bad object than to be completely alone, and a frantic and impulsive search for escapism (alcohol and drug consumption, fights, and getting into dangerous situations). In contrast to the first 2 states, patients can no longer psychologically reflect and intentionally decide to actively cope or connect in the third, alone/abandoned state. Gunderson notably characterized BPD as a condition of intolerance of aloneness.[37] In this state, patients have themselves abandoned efforts to reactivate a link but they have not abandoned the possibility of an ideal presence and thus can be contained by bystanders' efforts to rescue them (eg, hospitalizations).

Despairing State

In the fourth state, the despairing state, in contrast to the previous alone/abandoned state, important others become absent from the subject's mind and no longer appear as a resource that would help to soothe painful emotions that feel impossible to bear. In this state, patients with BPD become inaccessible, and external interventions that rely less on the patient's collaboration may be necessary if suicidal behaviors are present or imminent. Thus, patients often need a significant period of "concrete holding" (eg, in a hospital or sometimes a prison if externalizing acts prevail) to return to the connected state. This "holding" serves no

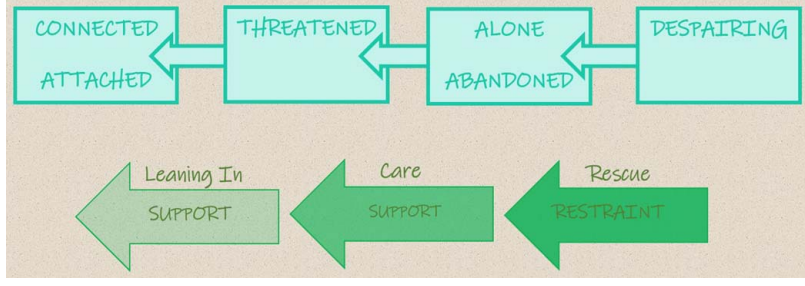

FIGURE 4. Interpersonal links.

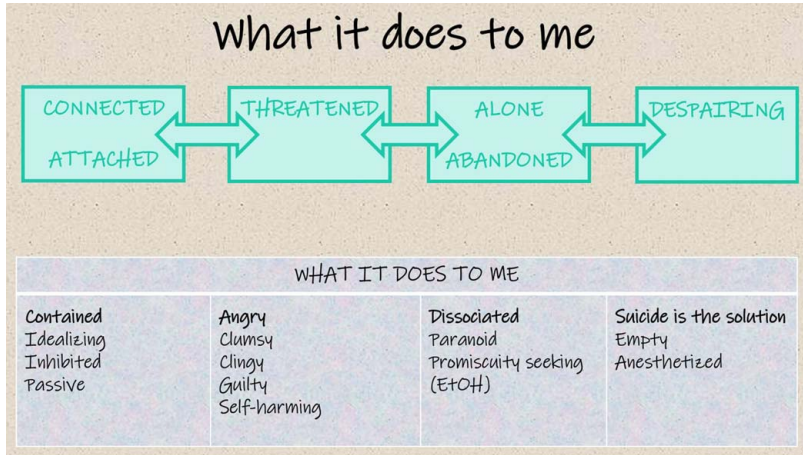

FIGURE 5. Predominant emotions or state of mind according to the state of attachment.

positive therapeutic role in and of itself, but rather is employed to prevent unsafe actions from occurring. The caveat is that the containment function of a hospital is often concretely interpreted by patients as lifesaving, and thus can become an addictive solution to basic survival but at the price of offering the secondary gain of escaping unwanted responsibilities. While the IHS model provides a basis for conceptualizing how different symptoms of BPD evolve and function, it is not a treatment plan and does not encourage caregivers and patients to rely on a suicidal crisis as a compensatory measure to reinstate idealized dependent connections with others through hospitalizations.

It should be noted that GPM stresses the need to create a "holding environment" in each encounter with a patient with BPD—that is, that the patient develops the containing belief of being cared for by being in front of a concerned, consistent, responsive, and nonreactive caregiver. "Concrete holding" is the chosen term in the GPM model to describe the most helpful interventions for these patients in this most severe state. Patients with BPD can self-harm and/or commit suicide in each of the 3 last states, but successful suicides are more likely to occur in the despairing state because patients are not as ambivalent and there is an absence of adequate interpersonal interaction that would present opportunities to signal this ambivalence to significant others.

Interpersonal Stressors and Links

Switching between the 4 states shown in Figure 2 occurs rapidly in the context of different interpersonal stressors (Fig. 3). Therefore, reflecting with patients on the characterization of the stressor at hand allows us to think with the patients about what has put them into crisis, and so anticipate a further slide into even more risky and unreachable states.

Interpersonal links are likewise not the same, as they depend on the patient's attachment. These links allow us to think with the patient and the multidisciplinary team about what type of care patients with BPD will best respond to in times of crisis: mostly psychologically oriented interventions in the threatened state, psychiatric case-management guidance in the alone/abandoned state, containment when the patient is in the despairing state (Fig. 4).

IHS Ruler

Our psychoeducational tool, the IHS Ruler, is shown and described below. It is based on a visual analog scale for IHS that we developed in collaboration with nurses from our unit. It is user-friendly and more substantive than an abstract explanation or discussion. This tool integrates the attachment-based formulation in the IHS model by linking 3 scales to each attachment state: a predominant emotion ("What it does to me" scale Fig. 5), a way of making the

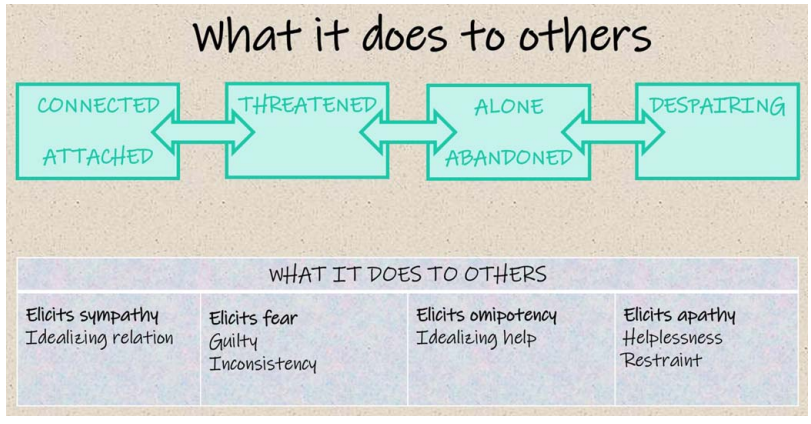

FIGURE 6. Predominant emotions or state of mind elicited in others according to the state of attachment.

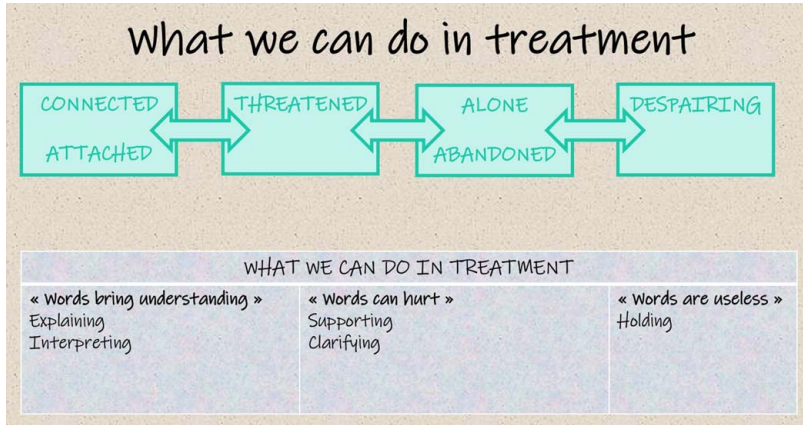

FIGURE 7. Predominant therapeutic interventions according to the state of attachment.

other react ("What it does to others" scale, Fig. 6), as well as indications for the most effective therapeutic interventions possible ("What we can do in treatment", Fig. 7).

"What It Does to Me" Scale

This component of the IHS Ruler summarizes and expands the IHS model as we know it, organizing a disparate set of emotions or state of mind of patients with BPD in terms of the attachment state in which they find themselves (Fig. 5). In addition to characteristics already identified by the IHS model and corresponding more or less to DSM symptoms (eg, idealizing, self-harming, paranoid, dissociated), we have listed for each state some related emotions or states of mind that we frequently encounter with these patients, transcribed in their own words (eg, "inhibited," "clumsy," "clingy," "guilty," "anesthetized") to facilitate contact with the subjective experience of patients with BPD.

"What It Does to Others" Scale

This component of the IHS Ruler is intended to be used as a pragmatic device that allows the identification of countertransference feelings during the clinical encounter, by orienting the patient-therapist dyad when it slips into the different attachment states (Fig. 6). It also allows discussions during team meetings and supervisions of the different affective reactions that patients with BPD can elicit depending on the state of their interpersonal relationship with a specific caregiver. This allows the therapist and the team to process and contain the well-known, so-called "splitting" phenomena that GPM sees as being more "outside" the patient (ie, provoked by maladaptive interactions between 2 subjects, one of whom has BPD) than "inside" the patient (ie, only a reflection of an intrapsychic process).

"What We Can Do in Treatment" Scale

Finally, the last component of the IHS Ruler puts forward "good enough" therapeutic interventions (Fig. 7). In the despairing and alone/abandoned states, words and discussion are generally futile and only substantive actions seem to matter to the patient. Therefore, it is when the patient is in the connected state and receptive to the collaborative dialog that the clinical staff can introduce ideas using questioning to model the active but uncertain curious stance. However, it is in the threatened state that we can promote the most change in our patients with BPD by leaning in curiously. With support-seeking clarification of emotions, conflicts, and perceived abandonment, and by taking responsibility for eliciting difficult feelings in the patient, we can provide containment in the treatment situation. The response of leaning into the threat to facilitate verbal clarification for the patient can help little by little to detoxify maladaptive emotional and behavioral reactions driven by the idealized expectation that perfect availability, alignment, and agreement are the norm in relationships.

CONCLUSIONS

In this paper, we presented practical, user-friendly adaptations of psychoeducational tools for patients with BPD that are well-suited for use by multidisciplinary inpatient staff or outpatient nurse-based staff. We extended the use of the GPM-informed IHS concept beyond its explanatory potential to allow clinical teams to use it as a key BPD psychoeducational device. The IHS Ruler is a pragmatic tool that can provide preliminary psychoeducation for patients with BPD and their caregivers. Its ease of use and structured way of presenting the inner experience of patients with BPD in relation to their current interpersonal environment allows caregivers to establish a framework for internal reflection and sharing, discuss the causes of current transactions, and illuminate larger patterns in the causes of the patient's crises. Ultimately, this process can then help patients and the clinical staff who are supporting them to anticipate future problems, thus allowing the patient's IHS to be managed proactively by thinking first.

Using IHS with this visual tool permits caregivers to be clearer and more effective in their efforts to collaboratively explore the problems that these not-so-difficult-to-reach but more difficult-to-keep patients have, thus preventing ineffective episodes of care or early drop-outs. Future research directions could involve providing IHS as a web-based tool[29] or an app that would allow fine-grained ecological momentary assessment to be collected and used to better understand and accompany the harsh day-to-day existence of patients with BPD.

REFERENCES

1. Gunderson JG, Singer MT. Defining borderline patients: an overview. *Am J Psychiatry*. 1975;132:1–10.
2. Plakun EM. A view from Riggs: treatment resistance and patient authority-XI. An alliance based intervention for suicide. *J Am Acad Psychoanal Dyn Psychiatry*. 2009;37:539–560.

3. Plakun EM. Psychotherapy with suicidal patients part 2: an alliance based intervention for suicide. *J Psychiatr Pract*. 2019; 25:41–45.
4. Gunderson JG. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*. American Psychiatric Association Publishing; 2014.
5. Gunderson JG. Disturbed relationships as a phenotype for borderline personality disorder. *Am J Psychiatry*. 2007;164: 1637–1640.
6. Gunderson JG, Lyons-Ruth K. BPD's interpersonal hypersensitivity phenotype: a gene-environment-developmental model. *J Pers Disord*. 2008;22:22–41.
7. Gunderson JG. *Borderline Personality Disorder*. American Psychiatric Press; 1984.
8. Choi-Kain LW, Gunderson JG. *Applications of Good Psychiatric Management for Borderline Personality Disorder: A Practical Guide*. American Psychiatric Association Publishing; 2019.
9. Downey G, Feldman SI. Implications of rejection sensitivity for intimate relationships. *J Pers Soc Psychol*. 1996;70:1327–1343.
10. Ayduk Ö, Zayas V, Downey G, et al. Rejection sensitivity and executive control: joint predictors of borderline personality features. *J Res Pers*. 2008;42:151–168.
11. Poggi A, Richetin J, Preti E. Trust and rejection sensitivity in personality disorders. *Curr Psychiatry Rep*. 2019;21:69.
12. Choi-Kain LW, Finch EF. The corrective experience of getting a life: case formulation using general psychiatric management as a framework to facilitate remission and recovery. In: Kramer U, ed. *Case Formulation for Personality Disorders: Tailoring Psychotherapy to the Individual Client*. Academic Press; 2019:61–75.
13. Bernanke J, McCommon B. Training in good psychiatric management for borderline personality disorder in residency: an aide to learning supportive psychotherapy for challenging-to-treat patients. *Psychodyn Psychiatry*. 2018;46: 181–200.
14. Weinberg I, Finch EF, Choi-Kain LW. Implementation of good psychiatric management for narcissistic personality disorder: good enough or not good enough? In: Choi-Kain LW, Gunderson JG, eds. *Applications of Good Psychiatric Management for Borderline Personality Disorder: A Practical Guide*. American Psychiatric Association Publishing; 2019: 253–280.
15. Finch EF, Choi-Kain LW, Iliakis EA, et al. Good psychiatric management for obsessive–compulsive personality disorder. *Curr Behav Neurosci Rep*. 2021;8:160–171.
16. Sharp C. Fulfilling the promise of the LPF: comment on Morey et al. (2022). *Personal Disord*. 2022;13:316–320.
17. Choi-Kain LW, Sharp C. eds, *Handbook of Good Psychiatric Management for Adolescents With Borderline Personality Disorder*. American Psychiatric Association Publishing; 2021.
18. Kernberg O. Borderline personality organization. *J Am Psychoanal Assoc*. 1967;15:641–685.
19. Masterson JF, Rinsley DB. The borderline syndrome: the role of the mother in the genesis and psychic structure of the borderline personality. *Int J Psychoanal*. 1975;56:163–177.
20. Adler G. *Borderline Psychopathology and Its Treatment*. Jason Aronson; 1985.
21. Benjamin LS. *Interpersonal Diagnosis and Treatment of Personality Disorders*. Guilford Press; 2002.
22. Wright AG, Ringwald WR. Personality disorders are dead; long live the interpersonal disorders: comment on Widiger and Hines (2022). *Personal Disord*. 2022;13:364–368.
23. Besch V, Greiner C, Magnin C, et al. Clinical characteristics of suicidal youths and adults: a one-year retrospective study. *Int J Environ Res Public Health*. 2020;17:8733.
24. Zimmerman M, Chelminski I, Young D. The frequency of personality disorders in psychiatric patients. *Psychiatr Clin North Am*. 2008;31:405–420.
25. Bateman A, Fonagy P. Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *Am J Psychiatry*. 1999;156:1563–1569.
26. McMain SF, Links PS, Gnam WH, et al. A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *Am J Psychiatry*. 2009;166:1365–1374.
27. Unruh BT, Sonley AKI, Choi-Kain LW. Integration with mentalization-based treatment. In: Choi-Kain LW, Gunderson JG, eds. *Applications of Good Psychiatric Management for Borderline Personality Disorder: A Practical Guide*. American Psychiatric Association Publishing; 2019:307–326.
28. Zanarini MC, Frankenburg FR. A preliminary, randomized trial of psychoeducation for women with borderline personality disorder. *J Personal Disord*. 2008;22:284–290.
29. Zanarini MC, Conkey LC, Temes CM, et al. Randomized controlled trial of web-based psychoeducation for women with borderline personality disorder. *J Clin Psychiatry*. 2017;78:16065.
30. Greiner C, Perroud N, Charbon P, et al. Trouble de la personnalité borderline: état des connaissances et des représentations auprès de praticiens francophones en santé mentale. *Encephale*. 2023;49:378–383.
31. Bowlby J. The Bowlby-Ainsworth attachment theory. *Behav Brain Sci*. 1979;2:637–638.
32. Panksepp J, Nelson E, Bekkedal M. Brain systems for the mediation of social separation distress and social-reward: evolutionary antecedents and neuropeptide intermediaries. In: Carter CC, Lederhendler II, Kirkpatrick B, eds. *The Integrative Neurobiology of Affiliation*. MIT Press; 1999:221–244.
33. Luyten P, Campbell C, Fonagy P. Rethinking the relationship between attachment and personality disorder. *Curr Opin Psychol*. 2021;37:109–113.
34. Hrdy SB. Evolutionary context of human development: the cooperative breeding model. In: Salmon CA, Shackelford TK, ed. *Family Relationships: An Evolutionary Perspective*. Oxford University Press; 2007:39–68.
35. Stepp SD, Whalen DJ, Scott LN, et al. Reciprocal-effects of parenting and borderline personality disorder symptoms in adolescent girls. *Dev Psychopathol*. 2014;26:361–378.
36. Winsper C, Hall J, Strauss VY, et al. Aetiological pathways to borderline personality disorder symptoms in early adolescence: childhood dysregulated behaviour, maladaptive parenting and bully victimisation. *Borderline Personal Disord Emot Dysregul*. 2017;4:10.
37. Gunderson JG. The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. *Am J Psychiatry*. 1996;153:752–758.