Year: 2024

Supported employment for individuals with personality disorders

Dunand Noëllie

UNIL | Université de Lausanne

FACULTÉ DES SCIENCES SOCIALES ET POLITIQUES
INSTITUT DE PSYCHOLOGIE

Supported employment for individuals with personality disorders

THÈSE DE DOCTORAT

présentée à la

Faculté des sciences sociales et politiques
de l'Université de Lausanne

pour l'obtention du grade de
Docteure és Sciences en psychologie

par

Noëllie Dunand

Directeur de thèse
Prof. Valentino Pomini

Jury
Prof. Koorosh Massoudi
Prof. Charles Bonsack
Prof. Julie Desrosiers
Prof. Nadine Larivière

LAUSANNE
2024

UNIL | Université de Lausanne

FACULTÉ DES SCIENCES SOCIALES ET POLITIQUES
INSTITUT DE PSYCHOLOGIE

Supported employment for individuals with personality disorders

THÈSE DE DOCTORAT

présentée à la

Faculté des sciences sociales et politiques
de l'Université de Lausanne

pour l'obtention du grade de
Docteure és Sciences en psychologie

par

Noëllie Dunand

Directeur de thèse
Prof. Valentino Pomini

Jury
Prof. Koorosh Massoudi
Prof. Charles Bonsack
Prof. Julie Desrosiers
Prof. Nadine Larivière

LAUSANNE
2024

UNIL | Université de Lausanne

Faculté des sciences sociales et politiques

IMPRIMATUR

Le Décanat de la Faculté des sciences sociales et politiques de l'Université de Lausanne, au nom du Conseil et sur proposition d'un jury formé des professeurs

- M. Valentino POMINI, Professeur à l'Université de Lausanne, Directeur de thèse
- M. Koorosh MASSOUDI, Professeur de l'Université de Lausanne
- Mme Julie DESROSIERS, Professeure de la Haute Ecole de travail et de la santé, à Lausanne
- Mme Nadine LARIVIERE, Professeure de l'Université de Sherbrooke au Québec, Canada
- M. Charles BONSACK, Professeur du CHUV à Lausanne

autorise, sans se prononcer sur les opinions de la candidate, l'impression de la thèse de Mme Noëllie DUNAND, intitulée :

"Supported employment for individuals with personality disorders"

Nicky LE FEUVRE
Doyenne

Lausanne, le 27 mars 2024

Abstract in English

The most effective vocational rehabilitation programme to date for people with psychiatric disorders is Individual Placement and Support (IPS). This model was specifically designed for people with severe mental illness (SMI). However, too few IPS studies have focused on individuals with personality disorders (PD) to reach a consensus. Nevertheless, research on this topic shows that people with PD face difficulties that lead to significant problems in the workplace. The obstacles commonly described as hindering professional life are often encountered by individuals with PD. This specific population could lead IPS job coaches to deal with challenges for which they may be less trained. This might potentially result in more mixed outcomes compared to what they can offer to individuals with SMI. This thesis aims to implement a new approach within the IPS framework to improve the support provided to participants with PD.

The first part of this thesis examined the need to adapt the IPS programme for individuals with PD through a comparative diachronic evaluation of IPS effectiveness in the Canton Vaud, Switzerland, for individuals with PD and those without PD. The effectiveness of IPS was indeed reduced for individuals with Cluster A and especially Cluster B PD, including borderline PD (BPD). In the second part, we explored the different difficulties and facilitators encountered by IPS job coaches for individuals with PD compared to those without PD. IPS job coaches reported more difficulties in supporting individuals with PD, and their reintegration hindrance stemmed from problematic behaviours affecting the relational alliance. These assessments lead to the third part of the thesis, which offers the training of job coaches in Good Psychiatric Management (GPM) for BPD to improve their support within the IPS context. On the one hand, the usefulness of this new modality was evaluated among job coaches. A qualitative study was conducted, aiming to assess the extent to which this addition led to practice changes among IPS job coaches, and how this evolution was perceived. On the other hand, the interest and effectiveness of the implementation were measured qualitatively and quantitatively among the concerned clients in a multiple case study. Job coaches positively assessed the integration of GPM into their practice. Clients were satisfied with their support and would recommend such care to other individuals who could benefit from it. Clients' preliminary evaluations showed promising results. Replicating these findings on a larger scale will be necessary to confirm these conclusions.

We can hope that the work presented in this thesis supports the improvement of clinical practice of IPS job coaches. It does not only facilitate their professional routine but also, and most importantly, contribute to achieve better vocational and non-vocational outcomes for the service users.

Résumé en Français

Le programme de réhabilitation vocationnel le plus efficace à ce jour est l'*Individual Placement and Support* (IPS). Ce modèle a été spécifiquement pensé pour les personnes présentant des troubles mentaux sévères (TMS). En revanche, trop peu d'études se sont penchées sur le cas des troubles de la personnalité (TP) pour permettre d'atteindre un consensus. Pourtant, la recherche à ce sujet montre que les personnes souffrant de TP présentent des difficultés engendrant des problèmes importants sur le lieu de travail. Les obstacles habituellement décrits comme entravant la vie professionnelle se retrouvent souvent chez les personnes souffrant d'un TP. Cette population particulière peut conduire les spécialistes IPS à gérer des difficultés pour lesquelles ils sont peut-être moins formés. Cela pourrait aboutir à des résultats plus mitigés par rapport à ce qu'ils peuvent offrir aux personnes avec des TMS. Cette thèse vise l'implémentation d'une nouvelle approche dans le dispositif IPS afin d'améliorer la prise en charge des participants au programme présentant un TP.

La première partie de cette thèse s'est penchée sur l'évaluation du besoin d'adaptation du programme IPS pour les personnes présentant un TP. Nous avons effectué une évaluation diachronique comparative de l'efficience d'IPS dans le canton de Vaud, Suisse, pour les personnes avec TP ou sans TP. L'efficacité d'IPS était effectivement diminuée pour les personnes présentant un TP du Cluster A, et surtout du Cluster B, comportant notamment le TP borderline. Dans la seconde partie, nous avons exploré les différents facilitateurs et difficultés rencontrés par les spécialistes de l'emploi IPS avec les personnes présentant un TP comparées à celles sans TP. Les spécialistes de l'emploi IPS reportaient plus de difficultés dans le suivi des personnes présentant un TP, et leur entrave à la réinsertion était le fruit de comportements problématiques affectant l'alliance relationnelle. Cet état des lieux amène à la troisième partie, proposant la formation des spécialistes de l'emploi au *Good Psychiatric Management* pour le TP borderline afin d'en améliorer la prise en charge dans le contexte d'IPS. D'une part, l'utilité de cette nouvelle modalité a été évaluée auprès des spécialistes de l'emploi. Une étude qualitative a été conduite, dans le but de voir dans quelle mesure cette addition a conduit à des changements de pratique parmi les spécialistes IPS, et comment ces modifications étaient perçues. Et d'autre part, l'intérêt et l'efficacité de l'implémentation ont été mesurés qualitativement et quantitativement auprès des clients concernés dans une étude de cas multiples. Les spécialistes de l'emploi ont jugé de manière positive l'intégration du *Good Psychiatric Management* dans leurs pratiques. Les clients étaient satisfaits de leurs suivis et recommanderaient une telle prise en charge à d'autres personnes pouvant en bénéficier. L'évaluation préliminaire des clients a montré des résultats prometteurs. Leur réplication à plus grande échelle sera évidemment nécessaire pour confirmer ces conclusions.

Nous pouvons espérer que les travaux présentés dans cette thèse soutiennent l'amélioration des pratiques cliniques des spécialistes de l'emploi IPS. Cela non seulement facilite leur routine professionnelle, mais surtout contribue à l'obtention de meilleurs résultats professionnels et non professionnels pour les participants.

1

[1] SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

Acknowledgments

I would like to dedicate this work to my grandma who passed away a day after I submitted my thesis to the members of my jury. I wish she could have been present until the end of this journey.

I would also like to thank all the people who have contributed, from near or far, to the elaboration of this work, and supported me all the way through. First, I thank Valentino Pomini, my supervisor, for believing in me at the very beginning. He gave me the opportunity to grow as an academic, in the different skills that are required for such careers. He has been listening, patient, and benevolent all along.

Second, I thank my jury members for accepting to be part of this path, and for their constructive feedbacks which helped me improve this work and bring it to another level. It was a pleasure to discuss and argue about my choices with experts in the field.

Then, I would like to thank all the participants in my research. I am grateful for people living with borderline personality disorder who accepted to share precious information about their life experiences. I am sure this thesis would not have the same value without their participation. I also thank my colleagues from RESSORT who also played the game and disclosed details about their prentice as IPS job coaches.

More generally, I thank all RESSORT team for giving me the space to work with them, even though they might have someone felt harassed by all kinds of questions a researcher can ask! Thanks to them for their patience and making these

moments a good time, whether at work or out with some of them. I want to thank Daniele Spagnoli, Dany, coordinator of RESSORT, for trusting me and supporting me in the elaboration of this work. She always offered her help and was attentive to my well-being. I am delighted to continue working in this amazing team, with such a humane and fair leader.

I also thank all my research colleagues from the Community Psychiatry Ward for the scientific and personal support, as well as the great atmosphere in the office. It has been a pleasure to share these years with you. I learned a lot. A special and huge thank you to my chef, Philippe Golay, who has been one of the reasons I stayed motivated through the tough times. His efficiency, responsiveness, and ability to adapt to situations, while being a great, encouraging and fun colleague to be around, were very helpful and inspiring.

I will also never forget all my colleagues from the university. They helped keep me motivated as well. The past 6 years have been long and emotional, and knowing that you were all there was one of the best supports I could receive. Thank you to the members of CARLA for helping me in my journey towards the doctorate title, especially Christine Mohr, who guided me and gave me confidence when I felt completely lost. Thank you to the members of the Doctoral Program in Psychology – Western Switzerland for integrating me into their committee. It was instructive and lots of fun to be surrounded by these people, especially during the PhD days, when the participants gave me strength and motivation every time! Thank you to Liliane, who welcomed me on my first day and with whom I shared the office. I am very grateful to have been accompanied by such a great friend all along the way. Thank you to the rest of la Fine Équipe, Jeanne, Cindy, Marie and Jasinta for

helping me start writing and showing me that this is not insurmountable! Thanks for the fun times, at the lake, singing, twerking, and more. Thanks to Domicele, my dear friend, for inspiring me with her passion for science, and for supporting me in this work. Thanks also for the long late-night discussions, all the trips, and so on. Thanks to Déborah for becoming such an important friend and landmark in the office, Michal for the cheering hot chocolates, concerts, beers and cocktails (with straw), Robert for his inexhaustible energy and all the projects he allowed me to share with him, Inez for introducing me the fun of public speaking, Amaëlle, Anaïs, Caroline, Claudia, Eileen, Elena, Elise, Esther, Gaëlle, Gloria, Livia, Loïs, Maël, Marion, Marine, Mélanie, Olivier, Sébastien, Simon, Sofia (…) for the chats, the drinks, the dances, the songs and the laughter. Thanks to Anne-Céline for the last-day proofreading! And thanks to all the others whose paths I crossed during those wonderful years at Géopolis. They are forever in my heart and memory. I am already feeling nostalgic!

Thanks to all my friends, who made sure I did not become a hermit and with whom I was able to relax in my spare time: Céline, Céleste, Florence, Irina, Tara, Audrey, Bérénice, Clément, Clothilde, Darine, David, Manu, Mélanie, Pauline, Pauline, Soraya, Shannon, Tamara, and the others that are further away but still count very much for me. I also thank Summer le p'tit chat, for its cuddles and purring that accompanied me during the final sprint, as well as all the artists I listened to, who often give me inspiration, courage and motivation!

Finally, I would like to thank my huge family, starting with my parents who gifted me with a fair-functioning brain (sometimes)! Thanks to them for the time they devoted to babysitting, which often helped me to continue with my work or

rest! It is also time to thank my children, Oliver and Elliott, for their patience when I was busy working or needed external help. Thanks to them for forcing me to take necessary breaks on weekends and evenings! These breaks were precious moments that I will cherish forever. Thanks to Thijs, without whom I would not have found the confidence to undertake such a work, and for reasoning with me when I was fed up and wanted a new professional project every day. He can now be in the position of my dear IPS colleagues who must deal with this typical difficulty, congratulations! Last but not least, thanks to my sisters, Adeline and Laurence, for the daily exchanges in good and bad times, and for all the laughs, they are my everlasting support!

Table of contents

2

[2] SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

1. Introduction

In the middle of the last century, the psychiatric asylum system, which involved the isolation of individuals with mental disorders, came under strong criticism. This marked the beginning of the anti-psychiatry movement, which viewed psychiatry as harmful. Deinstitutionalisation appeared in this context in the 1970s (Ailam et al., 2009; Perreault, 2015; Rissmiller & Rissmiller, 2006; Saint-Arnaud, 2001). However, this situation came with contested circumstances as well (Ailam et al., 2009; Saint-Arnaud, 2001). Many patients were left behind without support upon leaving the hospital (Nasrallah, 2008) and socially marginalised. They found themselves leaving the hospital without a home (Belcher, 1989), experiencing poverty, lack of social relationships, social and professional disconnection, and stigma (Nasrallah, 2008).

It is in response to these challenges imposed by deinstitutionalisation that social and community psychiatry emerged in the 1990s. This discipline aims to support the transition from psychiatric hospitals and the person's maintenance within their community through a coordinated mental health care programme. The central concerns become housing, work, and care outside the hospital. The ultimate goal is psychosocial rehabilitation, which means enabling individuals with chronic mental disorders to live happily and independently in their environment (Farkas & Anthony, 1989) and achieve a certain level of recovery (Grasset, 2004).

The concept of recovery as a possible perspective for growth for individuals with chronic mental disorders, despite the presence of after-effects or the persistence of deficits or symptoms, has gradually replaced that of cure (Anthony, 1993). Greater importance is then placed on the objective and subjective evaluation

of the individual's interpersonal, social, and vocational functioning, as well as their acceptance of persistent deficits (Davidson & Roe, 2007).

Many research studies have examined various aspects of recovery in psychiatric service users, such as the impact of vocational reintegration efforts. They have shown that employment has significant positive effects on the recovery of individuals with a mental disorder. An increase in quality of life, self-esteem, and autonomy, as well as an improved financial situation, is observed alongside a reduction in symptoms and stigma (Bejerholm & Eklund, 2007; Bond et al., 2001; Burns et al., 2009; Koletsi et al., 2009; Modini, Joyce, et al., 2016; Schuring et al., 2017; Strickler et al., 2009; van Niekerk, 2009). In Switzerland, professionally active people with mental illness recover better and more quickly than those unemployed, regardless of the severity of their disorder (OCDE, 2014). Conversely, unemployment negatively affects mental health. The prevalence of a mental disorder is higher in the global population of the unemployed than in the population of those who are employed (OCDE, 2012).

In their operational definition of recovery, Liberman and Kopelowicz (2002) assess vocational functioning as one of the four domains of recovery. Deegan (2002) and Rogers (1995), who themselves have experience with mental illness, also consider work to be central to psychosocial rehabilitation. They assert that it is an essential part of a person's identity. Taken from their literature review on the subject, Davidson et al. (2005) identify nine elements commonly cited as components of recovery. One of them is engaging in meaningful activities, which emphasises the importance of reintegrating social roles. Similarly, the scoping review by Gyamfi et al. (2022) identified three out of 12 mental health recovery

models that include employment in internal, external, or both processes, leading to healing. This is also the case in studies focusing on the experience of people with personality disorders (PD), who considered engagement in meaningful activities (Larivière et al., 2015; Ng et al., 2019), and more specifically in employment (Katsakou et al., 2012), as key components of their recovery journey. The functioning of people with borderline PD (BPD) seems to increase when they are integrated into the community, notably through work (Javaras et al., 2017).

Thus, work appears to be an integral part of the concept of recovery for individuals with mental disorders. Therefore, their vocational reintegration is one of the key areas of intervention in the field of community psychiatry. Indeed, most of them appear to want to work in the primary economy (Bedell et al., 1998; Bond et al., 1995; McQuilken et al., 2003; Millner et al., 2022; Mueser et al., 2001; Rogers, 1995; Secker et al., 2001). One of the challenges today is to best support individuals with any type of psychiatric condition in their journey towards employment. This thesis specifically focuses on the vocational reintegration of individuals with PD.

1.1 Mental disorders and employment

The question of employment is central to the well-being of people, including those with mental disorders. However, they face obstacles that vary across individuals, notably depending on the types of disorders they have. One way of classifying different mental disorders is to consider the degree of limitations they entail. Therefore, we commonly separate disorders according to their severity. Severe mental illness (SMI) is a term widely used to refer to conditions such as schizophrenia and chronic mood disorders like severe depressive disorders,

psychotic disorders, and bipolar disorders (Shinnar et al., 1990). These are disorders that persist over time and are prone to relapse and recurrence. They stand out due to their disabling nature, which severely impairs the social and professional functioning of individuals affected by them.

Individuals with SMI exhibit cognitive symptoms that affect executive functioning, leading to limitations in their professional skills and performance, as well as in the quality of their work (Green et al., 2004; Gualtieri & Morgan, 2008; Heinrichs & Zakzanis, 1998; O'Donnell et al., 2017). These people's health difficulties lead to high rates of absenteeism (Dean et al., 2004; Gilmour & Pattern, 2007; Lauber & Bowen, 2010; Zimmerman et al., 2010). This phenomenon of absenteeism is primarily caused by more or less extended hospitalisations. These can subsequently lead to strategies to avoid returning to the workplace due to a fear of failure, conflicts, and other concerns (OCDE, 2014). All of these factors result in job loss and unemployment (OCDE, 2015).

Furthermore, the work itself can exacerbate their symptoms (Marwaha & Johnson, 2005). Finally, their limitations also prevent them from feeling self-worth during job searches (Marwaha & Johnson, 2004). They face employer stigmatisation, often compounded by self-stigmatisation, making their access to employment particularly problematic (Corrigan et al., 2012).

Common mental disorders (CMD), such as depression, anxiety, and substance-related disorders, pose different challenges. People with such a condition are twice as likely to be unemployed as those with no mental health issues. Yet they are only half as likely to be unemployed as people with SMI (OCDE, 2015). CMD is more associated with presenteeism, which refers to being at work without being

productive, and short-term absences than with the long-term absenteeism typically found in SMI (Henderson et al., 2011; Sanderson & Andrews, 2006). The reasons for this can include reluctance to take sick leave within the corporate culture, fear of the stigma associated with such an act, or the failure to recognise these CMD as real illnesses requiring recovery time.

Lastly, PD do not fall univocally into either SMI or CMD. Yet, individuals with PD are more likely to experience significant negative professional consequences, such as being recognised as disabled, compared to people with other mental disorders (Amundsen Østby et al., 2014). This suggests a greater functional impairment of PD even though it is not usually classified as a SMI. Over 40% of them are recipients of disability benefits (Kramer et al., 2023; Zanarini et al., 2009) and PD are the most represented psychopathological category at the Swiss Invalidity Insurance (Schuler et al., 2016). Indeed, nearly half of employed people with a PD experience workplace difficulties (OCDE, 2014). According to Baer and Fasel's (2011) results, in contrast to other psychiatric disorders, the behaviours of persons with a PD are not seen by employers as manifestations or consequences of a real illness but rather as signs of controllable lack of willpower. They arouse irritation and anger rather than compassion and empathy. In half of the professional groups that include a member with a PD, the work atmosphere deteriorates, which is less often the case with other mental disorders (Baer & Fasel, 2011). Therefore, persons with a PD are highly at risk of being dismissed (Baer & Fasel, 2011; Ettner et al., 2011). Individuals affected by these types of disorders have a higher rate of unemployment than those with other pathologies (Knudsen et al., 2012). They experience longer periods of unemployment than people without a PD (Reich et al.,

1989). The OECD (2014) indicates that in Switzerland in 2010, 80% of individuals with a PD were unemployed, which places these disorders on par with SMI.

Furthermore, the obstacles faced by individuals with PD in vocational reintegration differ from those encountered by people with SMI or CMD. The professional situation of persons with a PD is hindered and made precarious by their problematic interpersonal relationships. The typical dysfunctions observed in PD appear less during job access than during the work period. These people actually have difficulties in maintaining their employment (Elliott & Konet, 2014; Hengartner et al., 2014; Hennessey & McReynolds, 2001), and in some cases, they voluntarily contribute to their job loss (Sansone & Wiederman, 2013). They have problems with colleagues and employers and risk rejection (Ettner et al., 2011). In Switzerland, 80% of employees at risk of dismissal are involved in relational problems: refusal to admit mistakes and blaming others (46%), marked and unpredictable changes in mood and mindset (39%), resistance to following instructions (34%). These manifestations can be recognised as common symptoms in individuals with a PD (Baer & Fasel, 2011).

The PD most extensively studied in the literature is BPD. It is associated with cognitive deficits, which affect their employment situation, and are different from those experienced by people with SMI, who display signs such as disorganisation and avolition (Demjaha et al., 2012). Individuals with BPD present a dichotomous way of apprehending situations and people, which can cause negative interpretations in the workplace (Reed & Zanarini, 2011; Zanarini et al., 2013). They also show deficits in social cognition, executive functions (Bozzatello et al., 2023), attention, memory, and decision-making (Folesani et al., 2022), which

are associated with their disturbed identity (Hoffman Judd, 2005) and impulsive behaviours (Ghanem et al., 2016; Juurlink et al., 2019; Kaplan et al., 2020; Larivière et al., 2022; Sio et al., 2011; Svaldi et al., 2012). Impulsivity notably stems from BPD's typical difficulty with self-knowledge, as well as from this disturbed and unstable identity, which in turn lead to ambivalence, uninhibited choices, low work functioning and engagement, particularly because of a lack of meaning in working activities (American Psychiatric Association, 2015; Gad et al., 2019; Juurlink et al., 2019; Larivière et al., 2022; Wilkinson-Ryan & Westen, 2000). The presence of impulsive behaviours, such as substance abuse or reckless conduct, can prevent the individual from fulfilling their social roles and obligations, which can negatively impact their academic and professional outcomes (Bagge et al., 2004). This impulsivity would disrupt self-regulatory behaviours that are crucial for professional activities. Sio et al. (2011) conducted a study involving 60 individuals with BPD. Among them, 68% exhibited impulsive traits. Impulsivity is indeed one of the diagnostic criteria for BPD according to the DSM-5 (American Psychiatric Association, 2015). In this research, it was the only criterion associated with professional difficulties; 93% of unemployed individuals presented this trait. Also, their theory of mind is impaired, which causes them to be mistrustful and have difficulties in mentalising (Galvez-Merlin et al., 2024; Zegarra-Valdivia & Chino Vilca, 2019).

These dysfunctions result in problematic interpersonal relationships (Galvez-Merlin et al., 2024; Roepke et al., 2012; Zegarra-Valdivia & Chino Vilca, 2019). It has been repeatedly shown that individuals suffering from this specific disorder not only have severe functional difficulties but deficits in interpersonal

skills as well, which also negatively affect their professional trajectories (Dahl et al., 2017; Larivière et al., 2022; Skodol et al., 2002). Regarding these interpersonal aspects, persons with BPD typically challenge relationships, resist constraints, engage in splitting, and experience stigmatisation from themselves, society, employers, and healthcare personnel (Bonnington & Rose, 2014; Dubreucq et al., 2020; Juurlink et al., 2019; Kealy & Ogrodniczuk, 2010; Lanfredi et al., 2021; Newton-Howes et al., 2008; Stalker et al., 2005). In turn, stigmatisation prevents people with BPD from disclosing their condition and difficulties in the workplace (Juurlink et al., 2019; Larivière et al., 2022). Their deficits in emotional and behavioural regulation can be characterised by parameters such as rigidity, external causal attribution (Black et al., 2004; Dahl et al., 2017; Juurlink et al., 2019; Larivière et al., 2022) and impulsivity, as discussed hereabove.

All these limitations often lead individuals with BPD to experience physical and mental disability (Zimmerman, Martinez, et al., 2012). Among all types of PD, individuals with BPD report the lowest level of interpersonal functioning. They also find their jobs stressful and challenging in terms of problem management (Jovev & Jackson, 2006; Juurlink et al., 2019; Larivière et al., 2022). They tend to engage excessively in work activities and lose balance with other life spheres (Juurlink et al., 2019; Larivière et al., 2022). Because of all these experienced challenges regarding employment, people with BPD are often worried and desperate to return to work (Dahl et al., 2017; Juurlink et al., 2019; Larivière et al., 2022).

PD with traits other than borderline have been much less studied. Nevertheless, Hengartner et al. (2014) suggest that all PD are associated with a low level of education, conflicts at work, dismissal, demotion, and unemployment.

However, their occupational difficulties vary depending on the personality trait: Those in Cluster B are the most problematic in terms of employment, followed by those in Cluster A, and finally, those in Cluster C. For instance, individuals with obsessive-compulsive PD are more conscientious, which proves to be a relevant asset in the professional world (Barrick et al., 2001; Samuel & Widiger, 2010).

1.2 Models of vocational rehabilitation

To address the mentioned difficulties, several vocational rehabilitation programmes have been developed to help individuals with psychiatric disorders regain employment. Different waves have succeeded one another, each with its own philosophy and level of evidence.

1.2.1 Different models of vocational rehabilitation

The initial vocational rehabilitation programmes were of the Train then Place type. They prepared service users to reintegrate into the competitive job market, referring to jobs in the mainstream economy open to everyone, paying at least minimum wage without subsidies and with ordinary working conditions. For this preparatory purpose, they used structures for people with disabilities, such as sheltered workshops (Mueser et al., 2014). Despite the advantages these workplaces may offer individuals with psychiatric disorders, they rarely lead to, or may even interfere with, obtaining competitive employment (Bond, 2004).

Therefore, a vocational rehabilitation model, known as Place then Train, was developed in the 1990s. It advocates for the direct reintegration of service users into the competitive job market, without training or preparation. The development of different skills takes place once the individual is immersed in a professional

environment, with the idea that lengthy preparations only worsen dependence, stigmatisation, and community disconnection (Bond, 2004). The most commonly used term for this category of programmes is supported employment (Bond et al., 1995).

The Individual Placement and Support (IPS) model falls under the Place then Train category and has been the most studied and validated vocational rehabilitation programme. This model aims for direct integration into a competitive environment rather than a sheltered one, to promote the empowerment of the service user (Arveiller & Bouvet, 2018). The IPS model originates from the United States and was developed by Becker and Drake (1993). It is based on the following eight principles:

1. The goal is to access the competitive job market.
2. The programme does not exclude any client.
3. Job searches are based on individual preferences.
4. Job searches start in the first month of the intervention.
5. The programme is integrated into the healthcare teams with whom it collaborates.
6. The programme supports clients and employers on an individualised basis and for as long as they need.
7. The client receives personalised advice regarding government allowances, rights, and financial risks associated with the loss of assistance in certain cases of resuming gainful activity.
8. IPS coaches develop systematic connection with the job market.

In addition to the eight core principles, the programme advocates for quality contacts with various employers and for client and IPS job coach to meet in natural community settings. In practice, each job coach is free to deploy their own intervention techniques and can individualise their approach to each client they collaborate with, while adhering to the eight principles mentioned above (Bond, 2004). Thus, interventions' length and trajectories vary greatly from one person to another. A manual and a fidelity scale allow verification of the extent to which professionals adhere to the programme and identify any aspects that might warrant a change in their own practice (Bond, Peterson, et al., 2012). The scale includes items assessing the activity of IPS job coaches, such as the number of clients in their cohort and coverage of all stages of employment support–search, maintenance, etc. A second section focuses on the organisation of the centre, including frequent contacts with clinical teams and supervision. Finally, the evaluation measures the service provided by job coaches, such as issues related to disclosing clients' functional limitations to potential employers and contacts with the latter.

Concretely, job coaches trained in the programme conduct the intervention. They accompany clients in their efforts for work reintegration and retention. In principle, IPS intervention takes place in three distinct steps, not necessarily consecutive. Firstly, a brief vocational analysis occurs at the beginning of the programme. Each client works in collaboration with their job coach to establish a professional project. Secondly, the pair prepares together the job application and interview process. Thirdly, once employment is obtained, job coaches support clients and employers for as long as desired. In parallel, coaches develop

connections with the job market to create a reintegration network within which they could place interested clients (Dutoit et al., 2017).

In French-speaking Switzerland, this model was implemented as a pilot project in Lausanne in 2008 with the establishment of the *Réseau de Soutien et d'Orientation vers le Travail* (RESSORT). It is a community network programme for supported employment embedded within the Community Psychiatry Wards of the Department of Psychiatry of Lausanne University Hospital. It then gradually expanded to the entire Canton Vaud, with IPS branches appearing in 2014 in other areas. There is now a main centre in Lausanne, and smaller teams in Montagny-près-Yverdon in the North sector, Prangins in the West, and Montreux within the Nant foundation for the East Vaud sector.

1.2.2 International effectiveness of Individual Placement and Support

Since the inception of the model, several hundred studies have assessed its effectiveness. Marshall et al. (2014) have notably compiled 12 systematic reviews, including a total of 17 randomised controlled trials (RCT). Their assessment is clearly favourable to IPS compared to other types of vocational rehabilitation programmes for people with SMI. The positive results encompass vocational aspects: access to competitive employment (around 60% with IPS versus 25% in control conditions), time in the programme before obtaining a job (around 1.5 times quicker in the IPS condition), number of hours (around 3.3 times higher in the IPS condition) and weeks worked (around 2.6 times higher in the IPS condition), etc. Non-vocational aspects also benefit from IPS: hospital readmission rates (2 to 4 times higher in the control condition), scores of psychiatric symptoms, quality of life, social functioning, etc., measured on various scales. Moreover, this

effectiveness appears to persist over the long term: 67% of participants are competitively employed after 12 years of follow-up and roughly the same rate of people report better affective, psychosocial, and somatic outcomes as positive effects of work (Becker et al., 2007). Clients describe positive consequences on their recovery (Gammelgaard et al., 2017). A meta-analysis by Modini, Tan, et al. (2016) included 17 RCT–five of which were new compared to the study by Marshall et al. (2014)–and two follow-up studies. They also concluded with more favourable results in terms of reintegrating into the competitive job market through the IPS programme. IPS offers more than twice the probability of obtaining employment compared to other vocational rehabilitation programmes or treatments. This study also affirms the universality of this trend, regardless of the geographical and economic situation of the country, with somewhat fewer contrasting results in regions with a lower gross domestic product. A more recent meta-analysis on the topic has been conducted by Frederick and VanderWeele (2019) and included 30 RCT. Twelve of them had not been included in the studies by Marshall et al. (2014) or Modini, Tan, et al. (2016). Again, obtention of competitive employment, job tenure, income, and quality of life were better in the IPS condition than in the usual treatment conditions.

In a review by Suijkerbuijk et al. (2017) including 22 RCT about all types of interventions aiming at obtaining competitive employment for people with SMI, results showed again the beneficial effect of IPS with around 3 times more success in finding a job as compared to prevocational training programmes. The only interventions that might slightly have been more effective than supported employment, were augmented supported employment programmes, which

correspond to the integration of skills training of different sorts, to the classical supported employment model (Boycott et al., 2012). Reviews on augmented supported employment have been conducted more recently. One included seven studies and suggested the positive effect of adding cognitive and psychosocial skills training to standard IPS for people with SMI, in terms of employment, work hours, and job tenure. However, these results were not systematic across studies (Dewa et al., 2018). The other review included 10 studies (Vázquez-Estupiñan et al., 2018), six of which were included in Dewa et al.'s (2018) work. It concluded with the failure to show greater effectiveness of augmented supported employment over the classical IPS model. More research is needed to draw definite conclusions.

Of the studies reported in Modini, Tan, et al.'s (2016) article, nine were conducted in North America, three in Asia, one in Australia, and six in Europe. One of these was multicentric and gathered 312 people with SMI across six European countries, including Switzerland (Burns et al., 2007) and was also included in the two above-mentioned meta-analyses. It confirmed the vocational and non-vocational positive outcomes of IPS. 55% versus 28% of participants reached competitive employment, worked 4 times more, maintained their job twice as often, dropped out 3.5 times less, experienced hospital admission 1.5 times less often, and spent half as much time in the hospital under IPS as under the other vocational service. The study concludes that the effectiveness of the IPS model is proven regardless of the social policy and labour market contexts of each country. However, the authors noted differences according to each European country's socioeconomic context. A growing economy and high levels of social exclusion, which might motivate people to find work, predicts finding a job. Besides, the

benefit trap, defined as more generous welfare systems provoking a perceived or real financial disincentive to return to work, impedes successful vocational rehabilitation.

Another of these European RCT (Hoffmann et al., 2012) and its follow-up (Hoffmann et al., 2014) took place in Switzerland and included 100 participants. The authors once again confirmed the vocational effectiveness of IPS in the specific socio-economic context of our country. Nearly 60% of participants under IPS condition reached employment, compared with 25% in the traditional vocational rehabilitation group. The experimental group worked 2.5 times as many weeks, took almost half as long to reach employment, and 45% of clients assigned to IPS were still competitively employed after 2 years in the study, compared with 15% of the other group. These results remained stable after 5 years of follow-up. Additionally, intergroup differences in nonvocational outcomes became apparent at this stage. People in the IPS group were half as likely to be admitted to hospital, and spent more than half much time in hospital, as those in the control condition. At RESSORT, the effectiveness of IPS in terms of employment rates compared between the beginning and the end of the programme also concluded the programme's benefits (Besse et al., 2016).

1.2.3 Effectiveness of Individual Placement and Support for various populations

While the IPS model was initially developed for people with SMI, one of its fundamental principle states that individuals with any psychiatric disorder, at any stage of the illness, can participate in the programme. This is significant as no specific criteria regarding symptom severity, employability, or treatment adherence

are set (Arveiller & Bouvet, 2018; Becker & Drake, 1993). Therefore, evaluating its effectiveness in populations beyond those originally targeted by the programme is essential. Bond et al. (2019) recently compiled 11 RCT, only one of which was included in Marshall et al.'s (2014) and another one in Frederick and VanderWeele's (2019) previous work, which examined the effectiveness of IPS for populations other than those with SMI. These studies encompassed individuals with CMD, affective disorders, moderate mental health issues, post-traumatic stress disorders, substance-related disorders (including formerly incarcerated veterans), and spinal cord injuries. In each study, the employment rate during follow-up data collection was consistently higher in the experimental (IPS) condition than in the control condition. The likelihood of securing competitive employment was also higher in all studies for the experimental condition.

A preliminary study has investigated the effectiveness of IPS specifically for PD (Juurlink et al., 2020, 2022). This study did not reveal significant differences in outcomes compared to the population with SMI. However, it identified several limitations, including low statistical power, a small sample size, and the heterogeneity of PD. The latter point could explain the lack of intergroup differences, highlighting the need for further research on this matter. Indeed, Besse et al.'s (2016) results indicate that clients with PD, regardless of the specific type, may benefit less from IPS than individuals with SMI, for whom the model was originally designed. They hypothesized that PD clients might have higher professional expectations than typical SMI participants. These findings, coupled with reports from healthcare professionals across various clinical backgrounds

expressing challenges in managing people with PD (Newton-Howes et al., 2008), underscore the importance of further investigation into this issue.

These various studies emphasise the utility of expanding the IPS programme more broadly to assist vulnerable individuals in reintegrating into the workforce. However, they also highlight the lack of research on the effectiveness of IPS for more diverse populations than those with SMI, for whom the programme was originally conceived.

1.3 Personality disorders and treatment interventions

1.3.1 Definition of personality disorder

According to DSM-5, PD is an enduring pattern of behaviour and lived experience that notably deviates from what is expected in an individual's culture. PD are a source of distress, characterised by cognitive deviance, with altered perceptions of self and others, and affective difficulties in managing emotions, interpersonal functioning, and impulse control. This functioning is rigid and stable and typically appears by early adulthood (American Psychiatric Association, 2015). These disorders are classified into three broad categories:

- Cluster A comprises personalities that are odd, eccentric, and related to positive and negative symptoms of psychosis (strange thoughts, problems in interpersonal contact). It includes schizotypal, schizoid, and paranoid PD.
- Cluster B includes dramatic and emotional personalities marked by instability and impulsivity on one side, and excesses, transgressions,

and self-centeredness on the other. It gathers borderline, narcissistic, antisocial, and histrionic PD.

- Cluster C consists of anxious and avoidant personalities, and those exhibiting traits of dependence, submission, self-devaluation, inhibition, a need for control, order, or perfection. This cluster includes avoidant, dependent, and obsessive-compulsive PD.

PD affect approximately 12% of the general population (Volkert et al., 2018) and 25 to 92% of the psychiatric population (Beckwith et al., 2014; Kovanicova et al., 2020; Tyrer et al., 2015). BPD affects around 1.6% of the general population (Gunderson, Herpertz, et al., 2018). Comorbidities are very common for PD (Shah & Zanarini, 2018). More than 38% of people diagnosed with a mood disorder also have a PD, often BPD (Lenzenweger et al., 2007). Conversely, nearly 80% of individuals diagnosed with a PD, and 97% with BPD, have a concurrent mood disorder (Shah & Zanarini, 2018; Zanarini et al., 2004). Sixty percent of persons with a PD have at least one additional diagnosis (Zimmerman et al., 2005).

1.3.2 Treatment of personality disorders

Evidence-based research has mainly focused on BPD, which limits knowledge of effective treatments for other types of PD (Bateman et al., 2015). Long-term psychotherapy has proven to be the most effective treatment for BPD, whereas pharmacotherapy has been poorly tested and is less effective for this type of pathology compared to others. Medication can be used to alleviate specific symptoms, but it does not alter the person's functioning. Various types of therapies have shown efficacy for BPD (Bateman et al., 2015; Gunderson & Links, 2014), including dialectical behaviour therapy (DBT; Linehan, 1993), which is the most

validated approach, followed by mentalisation-based therapy (Bateman & Fonagy, 2004), transference-focused psychotherapy (Clarkin et al., 1999), and schema therapy (Young et al., 2003). With appropriate therapeutic care, most service users achieve durable remission. The remission rate is 91% after 10 years and 99% after 16 years according to the longitudinal study by Zanarini et al. (2012) cited in the literature review by Temes and Zanarini (2018), with most service users undergoing non-intensive outpatient treatment over biennial assessments. This improvement equals the absence of a formal diagnosis, as a consequence of the rapid resolution of acute symptoms (suicidal ideation, self-harming behaviours, dissociative states, etc.). Symptoms related to temperament (intense anger, chronic emptiness, fear of abandonment, identity disturbance, etc.) are more challenging to eliminate. The relapse rate is only 15%, unlike with mood disorders, for example. Recovery is defined as remission along with good social and professional functioning, which refers to having some meaningful interpersonal relationships, being vocationally engaged, on a sustained and full-time basis, and performing well in this activity. The recovery rate ranges from 60 to 80% after 16 years, which shows that even after remission, not all people will be able to function well, but most will.

In this sense, several psychosocial interventions have been developed in addition to the above-mentioned specialised psychotherapies (Temes & Zanarini, 2019). One of them is the Systems Training for Emotional Predictability and Problem Solving (STEPPS), which involves 20 manualised weekly group meetings of 2 hours (Blum et al., 2002). It is based on a psychoeducational programme and integrates a systems-training approach to teach clients specific and appropriate emotion and behavioural management skills. The STEPPS treatment has been

shown to be efficient in decreasing symptoms and improving quality of life, and seems appreciated by therapists and clients, even though the dropout rate is high (Ekiz et al., 2022). Other adjunctive interventions have been developed such as the Emotion Regulation Group Therapy (ERGT), which consists of a 14-week group therapy and focuses on decreasing self-harm behaviours, mediated by changes in emotion regulation (Gratz & Gunderson, 2006). This treatment option is efficient in that it reduces self-destructive behaviours, emotion dysregulation, and symptoms, and improves quality of life, with lasting effects (Gratz et al., 2014). An 8-hour manualised forgiveness skills psychoeducational module aiming at enhancing patients' strengths has been developed by Sandage et al. (2015). It is used in combination with DBT, and improves forgiveness, attachment insecurity, and symptoms. The positive effects remain present at follow-up. Zanarini et al. (2018) have developed and tested a web-based psychoeducation programme delivering various information about BPD. This intervention decreased impulsivity and increased psychosocial functioning. Symptoms continued to decrease a year later. Another internet-based self-management intervention to use in addition to BPD clients' usual treatment has also appeared recently (Klein et al., 2021). This intervention covers most of the content of schema therapy in eight unguided modules tailored to the user, and offers daily text messages as well as personalised exercises, increasing in difficulty over time. The recommended frequency for visiting the website is twice a week for half an hour. The entire content can be completed between 6 months and a year. However, its positive effect was as good as that of usual care alone. Cognitive remediation, usually applied to psychotic disorders and, more recently, affective disorders, has also emerged as a treatment option to target neurocognitive deficits present in people with BPD. It has shown

effectiveness on specific cognitive domains and psychosocial functioning but not on clinical symptoms severity (Pascual et al., 2015; Vita et al., 2018).

Some interventions for BPD directly target employment. Elliott and Konet (2014) created a job preparedness programme, called The Connections Place, to assist individuals recognised as having BPD. This intensive 4-month programme included skills training, application preparation, group meetings, various presentations by external speakers, and individual meetings with a job coach. The intervention underwent an uncontrolled pilot study. People with severe symptoms were excluded. Yet, almost half of the participants dropped out, and less than half of those who completed the programme were able to reintegrate into the job market. This confirms the existence of limitations in IPS-type reintegration programmes for clients with BPD. DBT, mentioned above, has also been adapted to the specific topic of work in different forms. Thus, Koons et al. (2006) developed DBT-W. It consists of a weekly standard 2-hour DBT skills training, followed by a 90-minute group meeting, focusing primarily on finding and keeping a job. The programme lasts for 6 months. Teaching, role-plays, and homework related to obtaining and maintaining employment are used. Each participant keeps two diary cards: one for standard health-related DBT-target for the therapist, the other for employment-related goals. In a pilot study of 12 participants, a third dropped out. The remainders demonstrated an improvement in mental well-being and a slight increase in the number of hours worked. Another adaptation of DBT is called Accepting the Challenges of Exiting the System (DBT-ACES) and is meant to lead individuals to leave the mental health system (Comtois et al., 2010). It is a year-long programme composed of weekly individual and group-based skills training. It is based on

exposure and contingency management procedures to stop avoidance behaviours and reinforce progress towards recovery goals, which include professional, interpersonal, and social functioning. Participants are required to find competitive employment or vocational training, otherwise they are excluded from the programme until they meet this criterion. The skills group focuses on DBT skills, as well as goal setting, problem-solving, reinforcement, dialectical thinking, reducing perfectionism, anger, depression, and anxiety, and strategies for working effectively with healthcare providers. A feasibility study was conducted with 30 participants, six of whom dropped out. The findings showed an increase in the probability of being employed, and quality of life, as well as a reduction in hospital admissions. These effects seem to endure after a year. Finally, DBT-Skills for Employment (DBT-SE) was developed as a brief group-based intervention (Feigenbaum, 2019). It follows the usual functions of standard DBT, with a focus on employment. It is a 16-week programme consisting of weekly 3-hour group meetings. A feasibility study included 41 participants, 13 of whom dropped out. 25% of the remaining participants attended all 16 sessions, 25% obtained employment, and a further 14% attended an interview. In the one-month follow-up, five additional participants had found an employment. Symptoms levels decreased while interpersonal and social functioning improved. Besides, as people with BPD report a misconception about their disorder in vocational rehabilitation programmes (Dahl et al., 2017; Juurlink et al., 2019), Larivière et al. (2022) recently conceptualised the Borderline Intervention for Work Integration (BIWI) using information from the field. They interviewed four individuals with BPD, conducted focus groups with occupational therapists and service providers in community organisations. They identified six domains on which efforts to reintegrate people

into the workforce should focus: meaning given to work, self-awareness and sense of competence, mental workload management, interpersonal relationships in the workplace, mental disorder disclosure in the workplace, and routines outside of work. The resulting intervention consists of nine weekly group sessions of 150 minutes and two face-to-face or online individual meetings of an hour. A last group session of 90 minutes takes place a month later. Sessions include group discussions on specific topics, working in a chosen community organisation, role plays, and the practice of stress and energy management techniques. In the meantime, clients meet career counsellors individually every 2 weeks, and can continue to do so after BIWI has ended. In a pilot study involving 10 participants, this intervention has shown that seven of them were engaged in a job or in a professional integration project, and that motivation to find a job either remained stable or increased for eight of them. Clients were globally satisfied with BIWI (Larivière et al., 2024). This intervention seems promising.

Efforts in the treatment of people with BPD have also focused on improving access to existing care. A stepped-care model emerged with the aim of addressing long wait times for treatment (Paris, 2013). It consists of a brief version of evidence-based therapies discussed hereinabove, composed of 12 weeks of integrative therapy delivered in individual and group modalities. Patients who fail to respond are then addressed to a more intensive treatment. Study participants who took part only in the short-term treatment version showed a decline in major BPD symptoms (Laporte et al., 2018). Finally, best practices for supporting individuals with BPD have been identified (American Psychiatric Association, 2001). They encompass a condensed version of what works in the specialised treatments mentioned earlier.

The structured treatment resulting from this approach leads to a significant improvement in various indicators. For example, symptoms and associated risky behaviours, as well as measures of overall and social functioning improve. These results are similar to those achieved by specialised treatments, such as Mentalisation-Based Therapy, even though the latter acts more quickly (Bateman & Fonagy, 2009). A model was then developed based on this foundation by Gunderson and Links (2014). This is called Good Psychiatric Management or General Psychiatric Management (GPM) and can be incorporated into the practice of community practitioners in any setting, without requiring extensive training or a significant restructuring of their usual tasks. GPM is accessible to professionals as one day of training is sufficient to display a change in staff's attitudes towards persons living with BPD (Keuroghlian et al., 2016; Masland et al., 2018), in contrast to specialised treatments that require years of training. It would therefore constitute a cost-effective addition to IPS practice to adapt to client with BPD, if we hypothesise that IPS is adapted to any kind of disorder, and that the shortcoming lies in the lack of knowledge of job coaches about how to deal with people living with BPD.

1.4 Good Psychiatric Management for borderline personality disorder

1.4.1 Need for training about borderline personality disorder in clinical practice

Healthcare providers often report difficulties in dealing with the PD population and hold stereotypes notably about BPD treatment because they lack the right tools, resulting in less enthusiasm for working with them (Cleary et al., 2002;

Deans & Meocevic, 2006; Forsyth, 2007; Kealy & Ogrodniczuk, 2010; Krawitz & Batcheler, 2006; Lanfredi et al., 2021; Sansone & Sansone, 2013; Stalker et al., 2005). Health professionals hold more stereotypes (Jobst et al., 2010; Knaak et al., 2015) and a more negative attitude towards BPD than other mental illnesses (Bourke & Grenyer, 2010), such as less sympathy (Markham & Trower, 2003). They feel discomfort faced with BPD clients who they see as manipulative (Commons Treolar, 2009) and dangerous (Markham, 2003; Woollaston & Hixenbaugh, 2008). They would rather not work with this population of service users (Black et al., 2011; Servais & Saunders, 2007). The common stigmatising beliefs about PD held among health caregivers (Gunderson & Links, 2014; Sulzer et al., 2016), as well as the frequent comorbidities, result in other diagnoses being often at the forefront of the person's assessment. PD may therefore go undetected.

1.4.2 Development of Good Psychiatric Management for borderline personality disorder

The prognosis for PD is favourable with good management, but specialists in the field are lacking. Moreover, the inefficiency of treatments can lead to a deterioration of service users' conditions and, therefore, high costs for public health. GPM serves as a solution to these shortcomings, facilitating access to treatment for service users. This approach provides useful tools for supporting individuals with BPD, including for healthcare professionals in the psychosocial field who are not psychotherapists. These best practices, unlike psychotherapeutic techniques and theories, rely more on common sense than on a rigid step-by-step approach and can be used in both psychotherapy and case management contexts. They are indeed useful for anyone working with individuals with BPD, whether they are

psychiatrists, psychologists (Links et al., 2015), social workers, caregivers, nurses, or mental health workers in general (Keuroghlian et al., 2016; Masland et al., 2018). Its ultimate goal is to improve the psychosocial functioning and autonomy of service users. “Work before love” is the message that GPM caregivers must convey, giving priority to vocational activities, which are the starting point to reach better relationships. GPM is a general treatment which encourages a comprehensive approach involving a range of different stakeholders, such as psychotherapists, case managers and families. Additionally, it displays guidelines of attitudes and behaviour that everyone can adopt in their practice. The first part of the training consists of shedding light on stereotypes about BPD held by healthcare providers in order to raise their awareness, reduce stigma and stress the importance of providing appropriate treatment.

1.4.3 Stereotypes hindering the treatment of individuals suffering from borderline personality disorder

BPD, long categorised as a difficult-to-treat disorder and often posing challenges for untrained professionals, is subject to persistent beliefs. As a result, psychiatrists are often reluctant to diagnose a BPD. This leads to an issue of underdiagnosis of BPD in many service users. Another category of disorders will then be favoured for them, such as anxiety, unipolar, or bipolar disorders. Therefore, treatment will be ineffective and will not lead to recovery in a reasonable timeframe (Tyrer et al., 2010).

Some of these prejudices, accompanied with their reconsideration, are as follows:

1. “Clients resist treatment and assault caregivers.” They mostly want to receive relief from their pain. Their attitude towards others, including health caregivers, are part of their symptoms. Psychoeducation is hence recommended.
2. “Clients rarely recover.” The prognosis is, in fact, comparable to other psychiatric disorders. 10% remit within 6 months and 25% and 50% after respectively 1 and 2 years. Relapses are infrequent.
3. “Suicidal risks are recurrent and engage treaters’ liability.” Frequent suicide attempts are a sign of inadequate treatment. Excessive fear of caregivers is a sign of inexperience and poorly structured treatment.
4. “Symptomatic improvement is possible only with intensive and specialised treatment led by an expert.” This is true for a minority of clients. For others, good practices are sufficient to improve their lives.

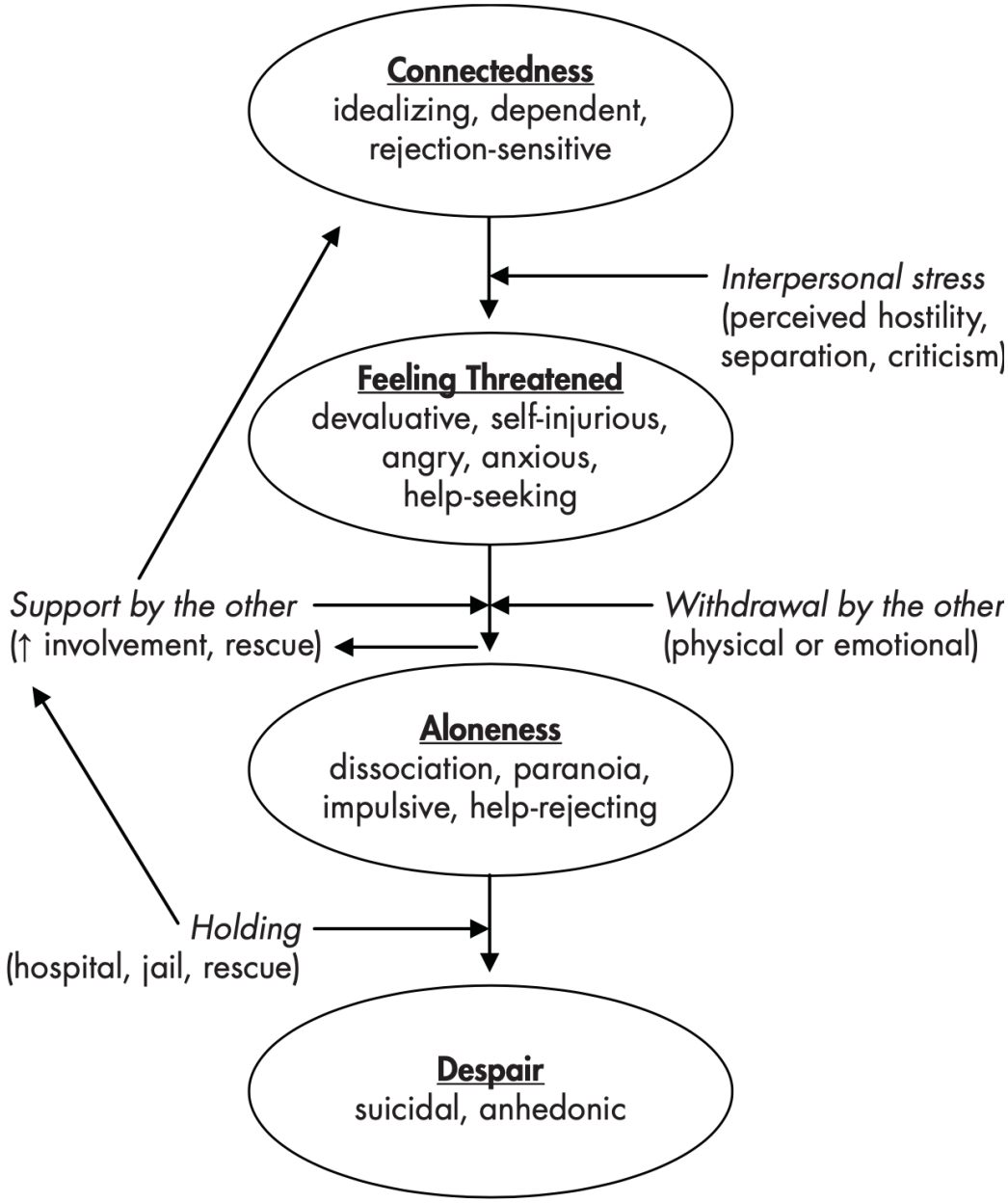
1.4.4 Model of interpersonal hypersensitivity

GPM is based on the theoretical model of interpersonal hypersensitivity (Figure 1.1) as the neurobiological foundation of the functioning of individuals with BPD (Gunderson & Links, 2014). The disorder is hereditary at 55%. It consists in an overactivity of the amygdala (easily excitable), coupled with an underactivity of the prefrontal cortex (less cognitive inhibition). It leads to a decrease in the ability to reflect, evaluate perceptions, and control behaviours and feelings. This would explain the high sensitivity to interpersonal stress (feelings of rejection or abandonment, or others' anger) or inconsistent, unpredictable, or ambiguous events,

characteristic of BPD. This model helps explain people with BPD's dependence on others, intolerance to solitude, as well as the oscillation of their symptoms. Interpersonal events trigger their emotional fluctuations, both in relapses and remissions. Symptoms, such as suicide attempts, self-harm, dissociation, denigration, or abandonment anxieties, may then appear.

Figure 1.1

Borderline Personality Disorder's Interpersonal Hypersensitivity



Note. Adapted from *Handbook of Good Psychiatric Management for Borderline Personality Disorder* (p. 14) by J. G. Gunderson and P. S. Links, 2014, American Psychiatric Association Publishing.

This model breaks down into four distinct phases describing the different states in which individuals with BPD can typically find themselves based on their relationship with others. These states range from the least concerning to the most

dangerous, with intermediate events that can cause the person to shift during a typical crisis from one stage to another in a short period.

The first state is the one of connectedness (1). The client feels attached to a close person and, consequently, is in a generally positive mood. Despite this, the person is in a state of alertness, on guard, and anxious about facing an event that could lead to possible rejection. In this phase, the client collaborates easily and is receptive to the offered help. They idealise the close person who responds to their fear of being alone, thus eliciting sympathy.

At this stage, the occurrence of interpersonal stress triggers hypersensitivity to rejection by the client. This can happen if the other person must leave, is running late, or is obliged to cancel an appointment, for example.

The client might then feel threatened (2). They experience strong negative emotions such as rage and may then engage in self-harming or denigrating behaviours to counteract the anxiety of being rejected. This induces typically fear and guilt in the other person.

The threatened state can prompt the other person to take on the saviour role and become more involved. This helps the client return to a connected state but reinforces the belief that they cannot manage on their own. Or the other person renounces to support the individual with BPD, which leads them to the third phase. Ideally, it would be helpful to assist the individual in understanding this state and finding solutions to return to a connected state.

Then comes the isolated state (3). The client withdraws, which intensifies their feelings of rejection, abandonment, and intolerance to solitude. Symptoms

such as paranoia, dissociation, and impulsivity typically emerge during this phase. The client then creates their own rejection or, conversely, triggers a saviour complex in the other person.

The personal and professional circle should, in theory, intervene proactively to demonstrate that they are not withdrawing, as others might. This helps the client return to a previous phase. If no support is available, the person may eventually enter the final phase.

Finally, the desperate state (4) is that of suicidal risk. The therapeutic alliance itself may not be sufficient at this point. A containing and constant environment, such as hospitalisation, is recommended to return to previous stages. This is not ideal as it also confirms the client's belief that they would be unable to cope on their own. However, it is the necessary solution when reaching this state.

Understanding this functioning allows anticipating progression to more advanced stages. It is possible to work around the four states in therapy to anticipate them and improve the client's symptoms. As will be developed later, a crisis plan helps avoid them and increases the client's sense of autonomy.

1.4.5 Characteristics of Good Psychiatric Management for borderline personality disorder

According to Gunderson and Links (2014), GPM as part of a comprehensive treatment is described by the following characteristics. First is case management. The disorder should be understood as psychosocial. Its treatment should address this particularity, rather than emphasising a pharmacological treatment that might be applicable in treating other psychiatric disorders. Medication will be useful only

to calm specific symptoms but does not enable the stabilisation of the general disorder. It is recommended to focus on the context in which the person lives and how they spend their days outside of therapy, rather than emphasising their psychology, as might be classically the case in psychotherapy.

Secondly, psychoeducation is crucial for the service user to understand and influence their experience. As a professional, one must be transparent, direct, and pragmatic. It is important to openly discuss the diagnosis, its causes, the limitations it implies, comorbidities, prognosis, both positive and potentially persistent negative outcomes, and different treatment options. This also helps to enhance the therapeutic alliance.

Thirdly, the intervention is geared towards goals. The second objective is symptom reduction and self-control. These are required to achieve the primary goal concerning the service user's professional and relational success.

Next is the multimodality of treatment, which may include individual psychotherapy, therapeutic groups, pharmacology when necessary, or social rehabilitation interventions. This aims to relearn responsibilities, be reliable, accept rules, avoid procrastination, have social interactions, and improve daily life.

Fifth, the duration and intensity of treatment are not fixed. They can vary based on its effectiveness. It is recommended to respond to the client's progress rather than their symptoms. This means that increasing the frequency of sessions without positive progress is detrimental, as it absolves the service user of responsibility and it is illogical to increase an ineffective treatment. Regular results are expected, which are visible in terms of symptomatic improvement or

engagement, for example. The service user and therapist together assess the usefulness and effectiveness of the treatment.

1.4.6 Good Psychiatric Management for borderline personality disorder guidelines

GPM is also made up of a list of good practices and attitudes to adopt throughout the care of individuals suffering from BPD. It is valid whether in the case of a global GPM treatment or an isolated intervention where the professional meets a person with BPD. First and foremost, it involves offering both formal and informal psychoeducation to the client. Formal psychoeducation includes informing about what is known or not known about the disorder (epidemiology, neurobiological origin, evolution, model of interpersonal hypersensitivity). Informal psychoeducation refers to reminding the client of their long-term goals, primarily that of regaining a social role. This latter modality involves providing advice, when necessary, for example, regarding professional and relational life, as well as daily tasks such as shopping or transportation. Psychoeducation helps relieve, gives hope, establishes realistic expectations about the course of care, assists the client in understanding and managing the disorder, and facilitates the therapeutic alliance. This last element occurs thanks to the initial reassurance that the person with BPD feels when learning that their problems are shared by others, that treatments can help, and that the people taking care of them have a relevant set of knowledge they can draw from.

Next, the therapist must be active, not reactive. They must be supportive, recognise the client's suffering, be empathetic, present, engaged, interested, and curious. This helps avoid feelings of hostility or abandonment in the interlocutor,

which could be triggered by underestimating their complaints. The therapist must also be willing to confront the client, but in a gentle way, to challenge passivity and question the person. These recommendations help prevent the client from feeling attacked or abandoned and stimulate them to adopt more adaptive behaviours. It is also crucial for the caregiver to think before acting, not to be reactive and overreact, not to make hasty decisions. They should instead reflect and discuss with colleagues if necessary, so as not to fall into passivity. For example, it is important not to decide too quickly on hospitalisation, a change in medication, or the frequency of consultations, as this could have deleterious consequences in certain situations. Questioning the client's needs and motivations is a solution to this risk. Thus, the therapist also acts as a role model for the person with BPD, whose behaviours are often impulsive.

GPM intervention also requires to be thoughtful and cautious. Those who practice it must dare to say that they do not know, that it is impossible for them to answer, that they are confused. They must be comfortable with this idea and even insist on it, while remaining clear about what is certain, without putting aside the framework, which must stay clear and directive to some extent. It is appropriate to be measured in one's words, introduce nuance, indicate one's own limits in the help that can be provided. Commitments that one is not sure they can keep should not be made. Here again, a modelling effect is expected on the client, who can then become more realistic. This promotes the defusing of their tendencies to extreme idealisation versus extreme devaluation, especially towards the caregiver. It thus contributes to counteracting their dichotomous thinking (black or white, good or bad, all or nothing, etc.).

The relationship must be cared for, by remembering that it is not only professional but real. The interaction is professional in that it involves a framework and certain rules, including those related to confidentiality. But it is also real since it involves two humans who can make mistakes and unintentionally make each other feel emotions. Remaining benevolent, specifying what one is willing to do or endure, and what one cannot accept is crucial. It is important to acknowledge mistakes, misunderstandings, how things could have been done differently, and not to encourage unrealistic expectations leading to idealisation. In this sense, it is possible to admit that other's recognition is flattering but that one's experience does not confirm the legitimacy of their projections. The therapist can allow themselves to reveal and talk about their experiences for the therapeutic benefit of the client. The development of such open and non-violent communication also acts as a model and contributes to the establishment of a certain trust and authenticity in the relationship, promoting interpersonal benevolence and respect. Emotions and beliefs that may cause shame in the client are normalised. Feeling, saying, doing, and thinking are allowed. Talking about oneself as a caregiver helps the service user feel less alone. They can thus regain hope.

Conveying that change is expected is another central recommendation of GPM. The caregiver is encouraged to emphasise that progress will be gradual and depend on the client's commitment. To assess the intervention and expectations, temporal boundaries, and realistic goals on both sides of the client-therapist relationship must be established, with regular assessments. Seeking to understand these results, both from the service user's and caregiver's side, is part of the intervention. To do this, the therapist remains attentive to signs from the client such

as motivation, punctuality, commitment, trust, connection, etc. Changes and the achievement of long-term goals (relational and professional) for service users depend on their efforts. Despite this seemingly strict framework, the therapist reminds the client that they will be there to provide support. These elements promote the service user's engagement and empowerment in their care, which encourages hope. Regular evaluations lead to questioning the added value of the intervention in the absence of change.

Fostering mutual accountability in the therapeutic relationship is characteristic of the recommended attitude to adopt with individuals with BPD. This is translated by the reminder that each–service user and caregiver–is responsible for their actions, whether good or bad. The therapist must let the client learn to recognise their needs so that they can identify how to return to a connected state. Sending them back the responsibility to communicate their needs when they are in difficulty is a way to restore their power of action. Previous conversations with the client must be reminded to help them learn from their errors: What were the conclusions, how to do better in the future? The caregiver, on their part, is also ready to acknowledge their mistakes, emotions, and attitudes and must emphasise that problematic behaviours are understandable and can change. Thus, the service user becomes an actor in their recovery. By relying on past situations, they learn to manage future stressful situations. Learning to welcome one's own emotions comes as a prerequisite for change. It is therefore not advised to try to reduce shame or guilt. These emotions can be positive and emphasised, as steps preceding regrets, apologies, or reconciliation.

To best treat a person with BPD, it is important to maintain a focus on life outside of treatment and take an interest in their relationships and activities. This means helping the client recognise that their emotional and behavioural problems are related to interpersonal events. Through this, they become aware of their relational functioning and its consequences. Interpersonal hypersensitivity can decrease by recognising how it activates. Taking an interest in the client's relationships, activities outside of therapy and current problems that can be addressed is key. Being aware that changes have effects in life and validating these progressions is necessary. Caregivers help manage stressful situations also by relying on external advice or ideas. For this purpose, it is possible to involve families or, at the very least, to develop a crisis plan. The client thus obtains tools to develop assertive and constructive behaviours rather than aggressive or submissive ones. This way, a balanced life that articulates work, leisure, relationships, domestic activities, etc., can emerge.

Finally, the GPM practitioner is encouraged to be flexible, pragmatic, and eclectic. Their role is to seek concrete solutions and dare original ideas. Sometimes it is enough to be patient, while waiting to find solutions, or if the crisis resolves quickly. It is preferable to adapt to the client's needs, choose the type of intervention based on their state (connected vs. threatened, alone or desperate), which will define their response. For example, advice, criticism, or interpretation, will be better accepted in a connected state. These same behaviours could increase the client's defences in a more critical situation where they would need more support. Defining availability together, rather than having predefined rules and, in general, using common sense, also in the application of the present guidelines, is needed. These

measures avoid alienating clients. It is also important to pay attention to one's own signs of negative transference (forgetfulness, boredom, irritation, disconnection) that provide clues about the treatment, not to be guided by one's own counter-attitudes. Situations that may deserve supervision or support from colleagues are thus identified.

GPM also addresses common problems that arise in interventions with individuals suffering from BPD. Advice to manage those typical issues exist if necessary (Gunderson & Links, 2014).

1.4.7 Effectiveness of Good Psychiatric Management for borderline personality disorder

The limited amount of research conducted on GPM to date has shown its effectiveness. In a RCT, McMain et al. (2009) compared the effectiveness of integrative GPM treatment with that of DBT. The latter is the most studied therapeutic approach that has demonstrated its efficacy in the treatment of BPD (Clarkin et al., 2007; Koons et al., 2001; Linehan et al., 2006). A total of 180 individuals with BPD participated in the study. They were randomly assigned to either treatment group for a duration of 1 year. Every 4 months, the number of suicidal and self-harm episodes, visits to the emergency department, visits to the emergency department for suicidal behaviours, days in psychiatric hospital, risk value of suicidal and self-harm episodes, symptom severity, depression, anger, health-related quality of life, symptomatic distress, and interpersonal functioning were evaluated. Both groups showed significant improvement over the months on all variables, except for health-related quality of life, where progress was not

statistically significant for either group. No intergroup significant differences were present.

The same team continued the study with its follow-up including 150 service users–the others had since dropped out. The same measurements were taken every 6 months for 2 years post-treatment (McMain et al., 2012). In both groups, the treatment effects had not diminished for any of the measured domains; Several had even progressed further. This research shows that individuals with BPD benefit as much from GPM as from the recommended standard treatment–due to its scientifically demonstrated effectiveness–for this population (Balaratnasingam & Janca, 2019; Gunderson, Masland, et al., 2018).

Furthermore, therapist adherence to GPM has been tested in this study. A self-report scale based on GPM principles was used. The correspondence between the client's and therapist's rating of the same session, and between the therapist's and that of two observers were assessed. Nine therapists completed the survey every 6 weeks for a total of 50 service users during a year. Authors conclude that the clinicians were adherent to GPM (Kolla et al., 2009).

The studies by Keuroghlian et al. (2016) including 297 clinicians and Masland et al. (2018), including 52, compared participants' attitudes before and after GPM training on a self-evaluation scale. They attest to positive effects on clinicians' attitudes immediately after GPM training. A decrease in the tendency to avoid and devaluate people with BPD and think that their prognosis was hopeless was reported. On the other hand, the professionals' sense of competence had increased. Masland et al. (2018) also assessed clinicians' attitudes 6 months after training: The positive effects persisted, and new elements that were not present

immediately after training emerged. Participants felt more empathy, comfort, and ease in discussing the diagnosis with individuals with BPD than before. Thus, GPM appears to be useful and appreciated by healthcare professionals in the long term. Therefore, it would be interesting to study its integration into the IPS supported employment context to address the apparent challenges faced by job coaches.

1.5 Implementation studies

Disseminating evidence-based approaches into practices is a real challenge in the field of mental health care. Research and clinical routine have difficulty communicating. Implementation notably lacks properly trained staff, facilities, leadership, trust from different stakeholders and funding. Additionally, it suffers from mental health stigma within the service (Murray et al., 2014). Relying on a clear and structured implementation plan to increase the chances of successful dissemination is therefore essential.

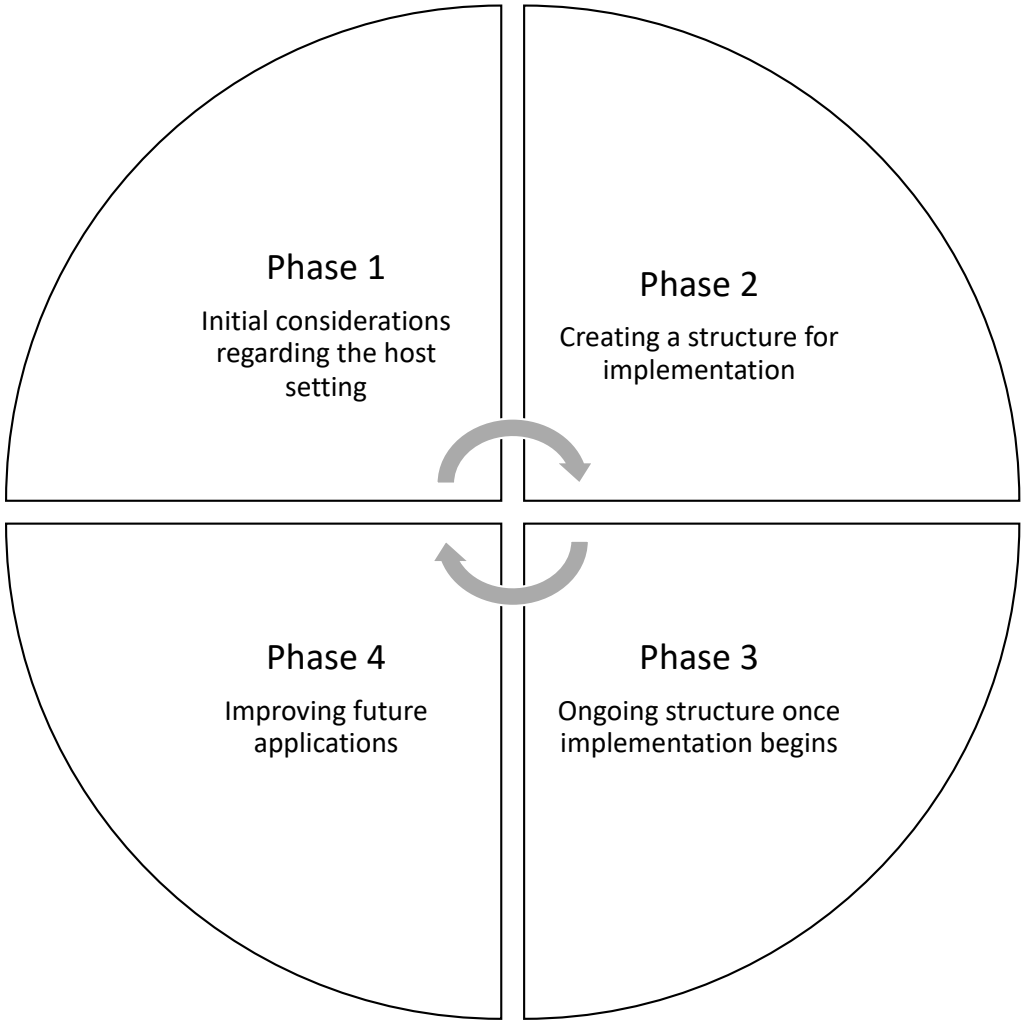
1.5.1 Implementation theory

One of the important factors influencing the success of an implementation is the implementation process itself (Durlak & DuPre, 2008). Proctor et al. (2009) postulate that evidence-based implementation in the mental health context requires both evidence-based treatment and evidence-based implementation strategies. Unfortunately, less importance has been given to the implementation science in the past years' literature. Still, some studies have focused on implementation processes, their effectiveness, and the way in which they can be standardised to achieve the best possible results. Implementation research contributes to the field of implementation science. Through their systematic review and synthesis of

implementation studies, Meyers et al. (2012) took into account 27 publications, with a total of 25 different implementation frameworks. They looked at the critical steps and specific related actions to reach quality implementation. They postulate that the latter is a systematic process involving the interaction between several features. From this review, they conceptualised the Quality Implementation Framework to guide implementations towards success. The framework applies to various settings. They highlighted a total of 14 steps grouped into four temporally successive phases (Figure 1.2). The directional flow of arrows between phases indicates the dynamic nature of the model. The steps they contain may continually be emphasised, revisited, or adjusted throughout the implementation process. Although a logical structure in which the steps unfold has been theorised, their actual implementation is expected to be influenced by various factors, such as context, resources, and logistical considerations.

Figure 1.2

Dynamic Interplay Among the Critical Phases of the Quality Implementation Framework



Note. Adapted from "The Quality Implementation Framework: A Synthesis of Critical Steps in the Implementation Process", by D. C. Meyers, J. A. Durlak and A. Wandersman, 2012, *American Journal of Community Psychology*, *50*(3-4), p. 475.

The first phase consists in the initial considerations regarding the host setting. Its eight steps are further described in Table 1.1. They essentially consist in assessing the ecological fit between the host setting and the planned innovation. The second step is the creation of an implementation structure. The implementation structural characteristics are established with the creation of an implementation team (9). This is defined as whom will be responsible for the implementation to support the front-line staff. The role of the members of this team must be clear. An

implementation plan (10) must also be developed. Specific tasks and deadlines must be clearly planned. Potential challenges must be anticipated when possible. In essence, the first two phases do not go beyond the planning stage, even though they may continually be updated throughout the whole implementation process. For example, staff might need extra training during the process. These 10 first steps should be addressed before implementation begins.

Table 1.1

Content of Phase 1's steps of the Quality Implementation Framework of Meyers et al. (2012): Initial Considerations Regarding the Host Setting

Steps	Content of each step
1. Needs and resources assessment	This should justify the importance for implementation, in what and whom it will help.
2. Fit assessment	This is meant to measure if the innovation suits the original setting, including its organisation, values, culture, etc.
3. Readiness for change	The degree to which the organisation is willing and able to implement the new feature should be assessed.
4. Possibility for adaptation	The need to adapt the innovation to the host setting, its capacity and its stakeholders should be addressed. These changes must be documented.
5. Buy-in from essential stakeholders	Explicit agreement from critical stakeholders is required. Leadership with decision-making power and front-line staff who will be affected by the implementation must be on board. It can be useful to work on resistance or negotiate the extent to which features from the implementation can be disregarded if necessary. It is possible at this stage to identify an implementation leader to inspire and lead the team to implement the innovation.
6. Building organisational capacity	Necessary skills and infrastructures must be identified and enhanced.
7. Necessary staff recruitment and maintenance	People in charge of the implementation are identified. They need to have or develop skills related to the innovation, its use, implementation science and implementation evaluation. They could be part of the existing company staff or be hired for the implementation purpose.
8. Pre-innovative staff training	Appropriate amount and content of training must be taught. It is important to ensure that the staff will be able to put into practice the innovation with the given tools.

Phase 3 is about the continuous implementation support strategies when implementation has started. It is in this phase that concrete changes take place.

Technical assistance or supervision (11) is necessary to guide front-line staff to properly conduct the innovation. This might result in additional training if necessary. A process evaluation (12) is also required. We need a concrete plan on how to measure strengths and limitations of the implementation over time. Data must be collected for this purpose. This leads us to the step of supportive feedback mechanism (13). It consists in communicating and act on the implementation key findings. These three steps take place during implementation.

The last phase is the one of improvement of future applications. As a result of the implementation, it is possible to retrospectively identify the strengths and weaknesses of the approach to learn from experience (14). These can be more widely communicated to other host settings interested in such an innovation. This last step occurs after implementation is complete.

However, none of the studies included in this review followed all the recommended 14 steps. Thus, this list serves as a flexible guide that leads to a better quality of implementation if its points are followed. Some steps might intentionally be disregarded if obvious in a given service (Meyers et al., 2012).

1.5.2 Implementation assessment

One of the key steps described by Meyers et al. (2012) regarding successful implementation is the evaluation of the latter. It was the step that was the most often present (96% of cases) across the studies that were reviewed for the purpose of their research. Implementation assessment has also been conceptualised numerous times to provide a theoretical framework for research. Proctor et al. (2011) conducted a narrative literature review on implementation outcomes in the field of mental

health. Their goal was to advance a clear terminology of the concepts currently used in the implementation science. Hence, they have defined a taxonomy consisting of eight main elements to assess and measure the results of an implementation. Rather than evaluating the success of an implementation exclusively with providers, or conversely, only with service users, the authors propose an assessment in terms of broader parameters that are present and measurable at various levels. Indeed, strategies for implementation must address contingencies of service systems, practice settings, human challenge of staff training and support, and other elements. Implementation success will vary based on these points (Proctor et al., 2009). The authors emphasise that implementation effectiveness and treatment effectiveness are two different things. Implementation outcomes precedes and impacts service and clients' outcomes. Improvement in clients' outcomes does not necessarily mean that an implementation was successful. Therefore, explicitly measuring implementation outcomes is capital.

Proctor et al. (2011) hence define acceptability (1) as the stakeholders' perception that the given implementation is satisfactory. It can be measured with teams and clients throughout the process. Adoption (2) is defined as the intention to apply changes related to the implementation. It is measured among providers. Appropriateness (3) is the perceived fit between the innovation and the configuration of the practice or the problem to be solved. It is assessed from the perspective of care providers and users. Feasibility (4) is the capacity of the innovation site to apply it. This is analysed with teams. Fidelity (5) is the degree of correspondence between actual practice and what was prescribed by the implementation protocol. This parameter is estimated within the service. The costs

of implementation (6) are calculated throughout the process within the institution. Penetration (7) is the integration of a practice into a service. It is therefore measured at the institutional level. Finally, sustainability (8) is the maintenance of innovations within the care team, measured in the organisation. The possible means of measurement of all these outcomes are diverse: administrative data, surveys, interviews, focus groups, observations, etc.

1.6 Overview of the thesis

IPS has a key principle of non-exclusion: Any person with a mental illness who wish to return to work in the competitive job market can, in principle, access this programme and be supported. Originally created for individuals with SMI, especially schizophrenia, psychotic depression, or bipolar disorders, IPS in its current form is not necessarily suitable for all mental health conditions, for which few studies have been conducted. However, other mental illnesses severely and negatively impact individuals' daily lives, specifically access to employment and job retention. This is particularly true for PD, which is associated with poor psychosocial functioning even after remission (Zanarini et al., 2012). This poses considerable challenges to their professional achievements, which may be difficult for IPS job coaches to overcome as employment is a constitutive feature of psychosocial functioning. Indeed, clinicians have shown general negative attitude (Knaak et al., 2015; Sansone & Sansone, 2013; Sulzer, 2015) and sense of incompetence towards individuals with PD (Cleary et al., 2002; James & Cowman, 2007). All of this leads to note that the limitations shown by individuals with PD are specific and different from the typical difficulties of people with SMI. Thus, the needs of individuals regarding their vocational (re)integration vary depending on

the dysfunctions they present. IPS addresses the limitations of people with SMI well but potentially less so those that characterise PD. The latter were not at the core of the model's design. It then seems necessary to adapt the support for these subjects. This idea has been suggested a few times but remains relatively unexplored to date (Drake & Bond, 2011). Nevertheless, IPS alone does not seem sufficient to enable IPS job coaches to adequately support people living with PD (Besse et al., 2016) and, by extension, to manage the difficulties related to the participants' personalities in the model. Unfortunately, perhaps a sign that this issue remains truly challenging to address, the effectiveness of vocational rehabilitation programmes for individuals with PD has been poorly studied.

Furthermore, the consistency between IPS principles and the guidelines for the care of people with PD is questionable. IPS advocates for a choice of a professional project based on the clients' vocational preferences and unlimited support over time. There is thus a focus on clients' desires. In contrast, recommendations for the care of individuals with BPD suggest establishing a stricter framework to counter the instability of self-image. This tendency characterises the disorder, and can lead to sudden changes in vocational aspirations (American Psychiatric Association, 2015). Indeed, these variations could hinder the sustainable establishment of a professional project in IPS and thus affect the intervention. This does not mean that IPS should stop focusing on BPD clients' professional wishes, but job coaches may need to help them choose one project, in which they can remain consistent throughout the intervention, rather than following potentially ever-changing plans. Also, the best practices identified by GPM for BPD encourage an adjustable care frequency based on the client's progress, not on their

desires like in IPS. There seems to be a misalignment between the recommendations for adequate care for individuals with PD on the one hand, and the practices and principles of IPS as it has been conceptualised on the other. Some clarifications might be judicious in the principles of IPS. These are very broad, focusing more on the objectives and tasks required, but do not contain aspects relating to the recommendation of a specific therapeutic attitude. Moreover, these adaptations would not involve a profound and opposing modification to the classic IPS model because there is no antagonism between IPS and GPM. Indeed, both advocate for vocational integration and are flexible enough not to counteract each other. Use of common sense, the need to set clear regularly assessed goals, the empowerment of the service user and the recommendation of multimodal treatment are all shared features of IPS and GPM. This shows the fit of implementing GPM into IPS, which is the second key step mentioned by Meyers et al. (2012) in their Quality Implementation Framework.

The limitations of people with PD in their efforts to reintegrate into the workforce, notably through IPS, invite us to consider how this process might be improved for them. This doctoral thesis was therefore prompted by the need to study IPS for people with PD. We have explored this issue by proposing three key steps, divided into four sections presented in Chapters 2 to 5. The first stage aimed to use existing data to analyse whether the vocational effectiveness of IPS in the Canton Vaud, Switzerland, followed the general trend found in the professional field. In other words, we wanted to determine whether people with PD had different trajectories from those with SMI in the programme. It compiled the results of IPS at RESSORT over 7 years to verify whether the vocational reintegration of

participants with PD was indeed less effective than that of participants with SMI. This work is published as Dunand et al. (2023).

Concurrently, the goal of the second study was to highlight the difficulties and facilitators present in IPS care for individuals with PD versus SMI. The associated manuscript is published as Dunand, Seydoux, et al. (2024). Research interviews among IPS job coaches were conducted to compare the two types of interventions and explore their nature. The methodological choice of individual interviews was intended to give sense to the quantitative results obtained previously, and to enable participants to share their personal experiences and reflect on concrete examples encountered in their practice, to enrich our understanding of this new topic (Braun & Clarke, 2013). Taken together, these two first steps respond to the needs and resources, readiness for change, and buy-in from essential stakeholders assessments, which respectively constitute steps 1, 3, and 5 of the Quality Implementation Framework (Meyers et al., 2012).

The third step sought to improve both the comfort of job coaches and IPS outcomes for participants with BPD. To achieve this, GPM for BPD was implemented in the IPS team. This was meant to allow job coaches to adopt the recommended practices for this specific disorder. This last part was based on the assumption that introducing training would lead to a change in the practices of IPS job coaches, thereby impacting clients. We hypothesised that training and supervising the IPS team in best practices for BPD would better equip the job coaches, who would provide better support to their clients, leading to an overall improvement in IPS care. The objective of this stage was to evaluate the initial implementation of GPM within the team. Changes in practice, service users and IPS

job coaches' satisfaction, and the effectiveness of supported employment after this implementation were studied. This was first explored in a qualitative study gathering testimonials from IPS job coaches, presented in Chapter 4 and in a paper that is published as Dunand, Golay, et al. (2024). Our aim was to analyse the impact and contribution of the implementation of this simple intervention on actual IPS practices. A focus group was conducted after the training of the team in order to recreate the atmosphere of the teaching session, and because we did not expect participants to have an extensive matter of discussion at this stage as they had not been able to put into practice the new learned features. The goal was to debate as a team about what the training could bring them, obtain a general appreciation, simulate a typical team discussion, and eventually forget about the presence of a researcher. Nine months later, the job coaches were interviewed individually, this time focusing on the personal practice of each of them, their possible successes, and failures. The aim was also to obtain an insight into the participants' journey towards the potential application of the GPM principles (Braun & Clarke, 2013). The consequence of introducing GPM into IPS was also examined through mixed data analyses regarding service users, in a multiple case study constituting the fifth chapter of this thesis and an article that has recently been accepted for publication (Dunand et al., accepted). For this purpose, quantitative data were collected through questionnaires, and qualitative data through individual interviews. Here again, our interest lay in the clients' personal path through the intervention, which interviews lend themselves well to. We hoped that this method would help participants broach potentially sensitive topics with greater ease, and that it would avoid domination of some participants over others, as we were concerned to give everyone the opportunity to express themselves (Braun & Clarke, 2013). This method also gave

us the opportunity to discuss their quantitative results openly with the participants, in order to link both types of data. This last stage required to address steps 4 (possibility for adaptation, as we adapted the GPM training to IPS setting), 7 (necessary staff recruitment and maintenance), 8 (pre-innovative staff training), 9 (creation of an implementation team), 10 (development of an implementation plan), 11 (supervision), 12 (process evaluation), 13 (supporting feedback mechanism, by sharing these results) and 14 (learning from experience, in the discussions of these studies) of the Quality Implementation Framework by Meyers et al. (2012). The general discussion of this thesis further summarises the overall results in the light of this theoretical model. The ultimate aim of the present work was to achieve better vocational and non-vocational outcomes for service users.

3

[3] SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

2. Individual Placement and Support effectiveness for personality disorders compared to other mental disorders: A retrospective study[4]

2.1 Abstract

People with PD show severe work impairments. IPS is the most efficient vocational rehabilitation model for people with mental illnesses. However, no study has shown its effectiveness for people with PD from different clusters. This study aims at comparing this programme's effectiveness in four groups: PD Clusters A, B, and C, and other mental disorders. We conducted a retrospective record review study on supported employment intervention data from four centres of the Community Psychiatry Wards of Lausanne University Hospital and the Nant Foundation (Switzerland). We selected all service users who participated in the programme between 2014 and 2020, except from those with unclear diagnoses and those with fewer than 9 months of ongoing care as of 31 December 2020. Comparisons were made between activity type, activity length, time before finding a job, and income of the four groups. Individuals with PD Clusters A (N = 26) and B (N = 97) had poorer vocational outcomes than those in Cluster C (N = 34) or without PD (N = 309). Participants in Cluster B showed the highest level of difficulty, specifically at finding employment. IPS is less effective for participants

[4] Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (2023). Individual placement and support effectiveness for personality disorders compared with other mental disorders: A retrospective study. *Swiss Archives of Neurology, Psychiatry and Psychotherapy*, *174*(1). https://doi.org/10.4414/sanp.2023.03301

with PD Clusters A and especially B than for other groups. A reconfiguration of the programme for this population who presents significative work impairments might be warranted.

2.2 Introduction

Having a PD negatively impacts work functioning (DSM-5; American Psychiatric Association, 2015). It is associated with a low education level, work conflicts, dismissals, demotions, unemployment (Hengartner et al., 2014), disability (Amundsen Østby et al., 2014) and early retirement (Korkeila et al., 2011). OECD (2014) reported 80% of unemployment in PD inpatients in Switzerland; This rate is similar for people with SMI (e.g. schizophrenia, severe mood disorders). Moreover, when interviewed about challenging staff members, employers frequently describe issues with interpersonal relationships, responsibility for one's actions, emotional stability, and acceptance of instructions. These impairments that are typical to PD often result in dismissals (Baer & Fasel, 2011; Ettner et al., 2011). Cluster B (i.e., dramatic, erratic), including antisocial, borderline, histrionic, and narcissistic PD, is the one most associated with disability–earlier age of work disability and failure to return to work. Cluster A (i.e., odd, eccentric), such as paranoid and schizoid PD, is second, with an expanded risk of disability. Cluster C (i.e., fearful, anxious), including avoidant, dependent, and obsessive–compulsive PD, is often considered the least problematic (Hengartner et al., 2014; Lang & Hellweg, 2006), with a similar functional impairments level as other common disorders (Skodol et al., 2002).

Vocational rehabilitation programmes have been developed to help psychiatric service users regain employment. The IPS model of supported employment gained worldwide interest and demonstrated the best efficacy, notably higher employment rates and fewer days before finding a job compared to control conditions (Frederick & VanderWeele, 2019). IPS targets client quick reintegration

into the competitive job market (i.e. regular paid jobs available to everyone, with equal conditions for all workers), stating that employment contributes greatly to their well-being by reducing symptoms and providing meaning to their lives. Anyone with mental illnesses can join IPS and benefit from the individual support the job coaches offer (Bond et al., 2019).

IPS appeared in the early 1990s and was created specifically for people with SMI, whose work rehabilitation is affected by stigma (Hampson et al., 2020), cognitive deficits (O'Donnell et al., 2017), increased absenteeism (Zimmerman et al., 2010) and decreased work performance due to their symptoms (DSM-5; American Psychiatric Association, 2015). Finding satisfaction in their social role is their primary motivation to work (Black et al., 2019). Supported employment shows effectiveness at professionally reintegrating this population (Bond, Drake, et al., 2012). People with PD display different rehabilitation-related challenges. This disorder is characterised less by symptom presentation than by functional, including work, impairments (Zimmerman et al., 2018). Dahl et al. (2017) argue that advances in vocational rehabilitation programmes are needed for these individuals.

Lately, IPS has been studied in populations beyond SMI (Bond et al., 2019). However, only two recent studies by Juurlink et al. (2020, 2022) have addressed the case of PD. It indicated that IPS would work as well for PD clients and for people with SMI. However, PD subtypes were not compared. They, as well as several researchers in the past years (Besse et al., 2016; Bond et al., 2019), emphasised that further research on IPS effectiveness for people suffering from PD is necessary.

This study aims to explore differences in vocational results when participants exit the IPS programme, according to four groups: PD Clusters A, B, and C, and other mental disorders. Given general impairments level of these groups (Hengartner et al., 2014; Lang & Hellweg, 2006; Skodol et al., 2002), we hypothesised that they would differ in terms of vocational outcomes, with the IPS participants in PD Clusters A and especially B showing poorer success than those in Cluster C and with other disorders than PD.

2.3 Methods

2.3.1 Setting

Since 2009, the IPS model has been implemented at RESSORT, a community network programme for supported employment developed by the Community Psychiatry Department of Lausanne University Hospital and extended to the Nant Foundation (Switzerland), whereby four centres take care of approximately 250 IPS participants yearly. Additional details on how IPS was implemented at RESSORT is described elsewhere (Besse et al., 2016; Dutoit et al., 2017; Favre et al., 2014).

IPS support time is unlimited; Intervention length varies considerably between participants depending on their needs. When engaging in IPS, participants are either unemployed or employed and seek assistance in finding or preserving an activity (i.e. job or training; Becker & Drake, 2003).

This research is a retrospective record review study using data from RESSORT. Access to existing routine institutional records was granted by the Human Research Ethics Committee of the Canton Vaud (protocol #2016-00768).

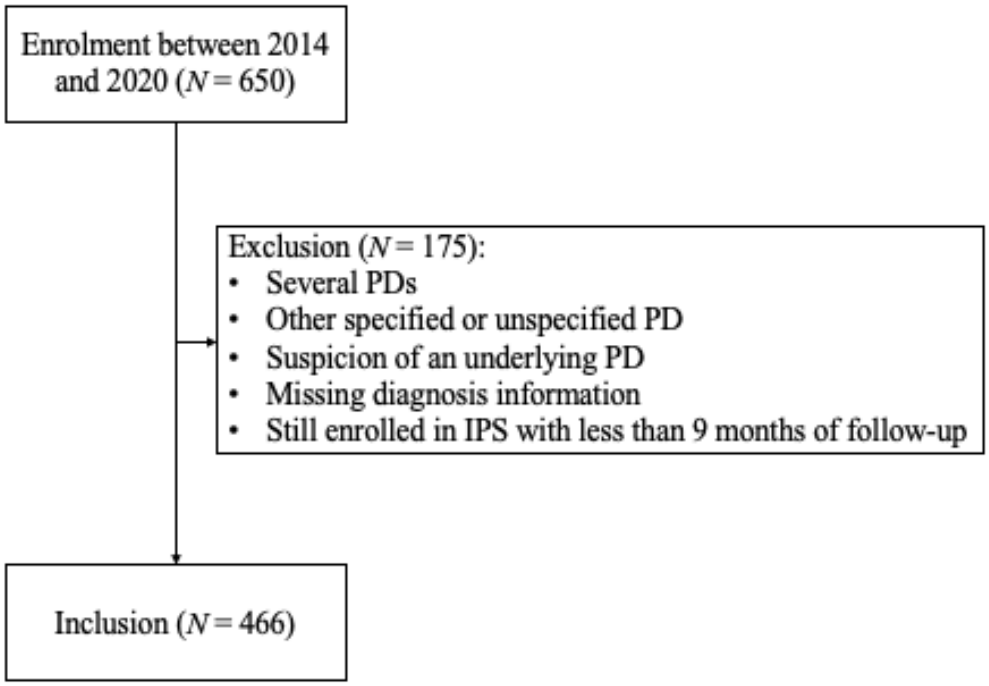
2.3.2 Participants

We extracted data from 650 service users who started participating in IPS at RESSORT between 1 January 2014 and 31 December 2020. We excluded RESSORT's IPS participants diagnosed with more than one PD or other specified or unspecified PD in this study since detailed PD diagnoses were not available and so we could not categorise them into one of the three DSM-5 clusters (American Psychiatric Association, 2015). We also excluded participants with suspected but not formally diagnosed underlying PD to avoid confusion in the results, as well as participants with missing diagnosis information.

Finally, because few jobs are found by persisting in IPS beyond 9 months (Burns et al., 2015), records from clients with fewer than 9 months of ongoing care at the end of 2020 were not included. Those might not yet have had enough time to display professional evolution. Conversely, those who chose to quit the programme before 9 months were considered to have reached their final goal and were therefore included.

Service users were categorised in four groups depending on the presence of a PD, regardless of any other mental disorder they had: PD Cluster A, Cluster B and Cluster C–official DSM-5 nomenclature (American Psychiatric Association, 2015)–and a group with no PD (Figure 2.1).

Figure 2.1
Sampling



Note. IPS = Individual Placement and Support; PD = personality disorder.

2.3.3 Measures

RESSORT database consists of participants' demographic and routine vocational information. It includes baseline evaluations completed when service users entered the programme and trimonthly evaluations until they exited the programme or at last available evaluation for people who were still enrolled when data were extracted. Participants' diagnoses, as assessed by their personal psychiatrists, were taken from their admission forms.

Six variables describing vocational outcomes were extracted from the database. The first variable was *activity type*, with four different values: (a) no activity; (b) sheltered job, internship, or job financed by disability insurance; (c) training; and (d) competitive employment. The second variable was *overall*

employment, which was the proportion of participants who were ever competitively employed within IPS. The third variable was *earnings main source*: salary versus another source of earnings (e.g., social or disability benefits). The fourth and fifth variables were *total duration of activity* and *longest period of activity* throughout IPS (either in competitive employment or in training, depending on participant's specific goal). Finally, we measured *time to first employment*–time between person's admission to the programme and their first competitive employment.

2.3.4 Statistical Analyses

After displaying descriptive statistics for each group, we compared the four groups (PD Clusters A, B, and C, and no-PD) on all outcome variables. Except for time to first employment, we used a Bayesian approach, which represents an alternative to the classic problem of multiple comparisons and allows an assessment of support for the null hypothesis (Golay et al., 2019, 2020). All 15 possible models were estimated. The first one was the homogeneous model (1, 2, 3, 4), stating that groups do not differ and are issued from the same distribution. It corresponds to the null hypothesis in the classical statistical framework. Another model was the heterogeneous model: (1) (2) (3) (4) (i.e., all groups are different from each other / issued from a different distribution). All other possible combinations–for instance (1, 2, 3), (4) or (1, 3), (2, 4)–were estimated. For continuous variables, the best (i.e., statistically strongest) possible Gaussian model (μ, σ^2) was determined by using the Bayesian information criterion. For nominal variables, the best multinomial model was determined using the exact likelihood with a uniform prior on all parameters (Noël, 2015). An equal prior probability of 1/15 was assumed for all models so that no model was favoured. This could be seen as an "uninformative prior" which

avoids the estimation of the posterior probability to be influenced by any subjective a priori belief. In this context, sensitivity analysis is not warranted. The Bayes factor was computed and provided a comparison between the best model and the homogenous model. A Bayes factor of 4 would indicate that the best model is 4 times more likely to be true than the homogenous model. Values over 3 are generally considered sufficiently important to favour one model over another (Jeffreys, 1961; Wagenmakers et al., 2011).

Additionally, activity duration analyses were run without participants who were never competitively active throughout IPS participation, to avoid a bias with those participants lowering the results, thus reflecting overall activity rates rather than activity maintenance. Kaplan-Meier survival curves, associated to a log-rank test aiming to compare survival of the groups, were used to illustrate time to first employment. This analysis was run without participants who were never employed within IPS and those who were already employed at admission. Missing data were dealt with by listwise deletion. IBM SPSS Statistics (Version 26) and the AtelieR package for R (Noël, 2013) were used. Differences were considered significant at $p < .05$.

2.4 Results

The final sample included 466 participants comprised of: (1) 26 people in Cluster A, (2) 97 in Cluster B, (3) 34 in Cluster C, and (4) 309 in the no-PD condition. Groups' sociodemographic characteristics and comorbidities are presented in Table 2.1. The groups did not differ on mean age, mean time in IPS, or rate of participants who completed only basic education, and were active at baseline. They did differ on gender, with men being the majority in all groups

except Cluster B but particularly so in Cluster A. However, post hoc analyses did not show gender differences in any outcome. They also differed on rate of participants who had been active within the past 12 months before admission, with a larger proportion of participants in Clusters B and C having had a recent activity. Psychiatric conditions other than PD were equally distributed between the PD groups, apart from psychotic disorders and anxiety disorders, which were more prevalent in Clusters A and C, respectively. The same trends were found in the subsamples of the analyses for which some participants were excluded. More than half of the PD participants had a comorbid mental condition. The different PD types were not equally present in all clusters, especially Cluster B which was mainly composed of BPD, and very few obsessive-compulsive PD were present in Cluster C, as visible in Table 2.2.

Table 2.1

Characteristics of Each Study Group

Characteristics	PD Cluster A (*N* = 26; 5.6%)	PD Cluster B (*N* = 97; 20.8%)	PD Cluster C (*N* = 34; 7.3%)	No PD (*N* = 309; 66.3%)	p
Men, % (*N* = 466)	92.3	36.1	67.6	57.0	< .001 [a]
Mean age (*SD)*, years (*N* = 466) [c]	38.7 (11.9)	37.1 (10.3)	38.4 (10.7)	35.0 (10.5)	.07 [b]
In a vocational activity within the past 12 months, % (*N* = 459) [c]	53.8	69.1	69.7	54.8	.04 [a]
Basic educational level (compulsory school only), % (*N* = 459) [c]	38.5	39.6	47.1	45.9	.65 [a]
Competitively employed or in training, % (*N* = 466) [c]	15.4	13.4	20.6	24.6	.11 [a]
Condition other than PD, % (*N* = 466) [c]	50.0	52.6	64.7	100.0	< .001 [a]
Psychotic disorders	19.2	2.1	5.9	33.3	< .001 [a]
Mood disorders	26.9	28.9	32.4	43.4	.03 [a]
Anxiety disorders	3.8	13.4	26.5	26.2	.006 [a]
Other mental disorders	7.7	12.4	23.5	15.2	.31 [a]
Mean time enrolled in IPS (*SD*), months (*N* = 466)	8.6 (8.4)	10.6 (10.4)	11.4 (9.6)	11.8 (10.4)	.41 [b]

Note. IPS = Individual Placement and Support; PD = personality disorder.
[a] Pearson's chi-square. [b] ANOVA. [c] At baseline.

Table 2.2

Number of Participants in Each Type of Personality Disorder

PD cluster	PD type	Number of participants (% of the cluster to which it belongs)
PD Cluster A	Paranoid PD	9 (34.6)
	Schizoid PD	17 (65.4)
PD Cluster B	Antisocial PD	7 (7.2)
	Borderline PD	81 (83.5)
	Histrionic PD	0 (0)
	Narcissistic PD	9 (9.3)
PD Cluster C	Avoidant PD	16 (47.1)
	Dependent PD	16 (47.1)
	Obsessive-compulsive PD	2 (5.8)

Note. PD = personality disorder

Table 2.3 presents the outcomes for activity type, overall employment, earnings main source, activity total duration, and longest period of activity duration at the end of the programme. Regarding the whole sample, two patterns emerged from the analyses:

Table 2.3

IPS Outcome Comparison Between Each Study Group at Last Evaluation

Outcomes	Cluster A *N* = 26	PD Cluster B *N* = 97	PD Cluster C *N* = 34	No PD *N* = 309	Best model	Bayes factor against null hypothesis	Probability of the best model to be true
Activity type, % (*N* = 466)					(2) (1, 3, 4)	34.10	0.663
Competitive employment	23.2	16.5	32.4	29.8			
Training	3.8	13.4	5.9	8.1			
Sheltered job, internship	11.5	4.1	8.8	13.6			
None	61.5	66.0	52.9	48.5			
Overall employment, % (*N* = 466)	30.8	30.9	38.2	42.7	(1, 2) (3, 4)	1.51	0.200
Salary as earnings main source, % (*N* = 465)	19.2	18.7	32.4	29.1	(1, 2) (3, 4)	1.60	0.257
Mean activity total duration (*SD*), months (*N* = 466)	2.31 (4.01)	2.44 (5.26)	3.71 (5.86)	4.19 (6.46)	(1, 2) (3, 4)	1.84	0.337
Mean longest period of activity duration (*SD*), months (*N* = 466)	2.08 (3.77)	2.13 (3.80)	3.35 (5.16)	3.87 (5.84)	(1, 2) (3, 4)	4.59	0.410
Mean activity total duration (SD), months (*N* = 197 [a]	6.75 (4.46)	6.94 (7.25)	9.23 (6.18)	8.56 (7.04)	(1, 2, 3, 4)	1.00	0.540
Mean longest period of activity duration (*SD*), months (*N* = 197) [a]	6.00 (4.54)	6.00 (4.44)	8.31 (5.22)	7.85 (6.28)	(1, 2, 3, 4)	1.00	0.436

Note. IPS = Individual Placement and Support; PD = personality disorder.

[a] Analyses performed only on participants who ever had a vocational activity during enrolment in IPS (PD Cluster A, *N* = 8; PD Cluster B, *N* = 32; PD Cluster C, *N* = 13; no PD, *N* = 144).

(a) For activity type, Cluster B strongly differed from all other groups, with a lower competitive employment rate (slightly above 1/6 versus almost 1/3) and a higher proportion of total inactivity (2/3 versus slightly over 1/2), compared to the other groups.

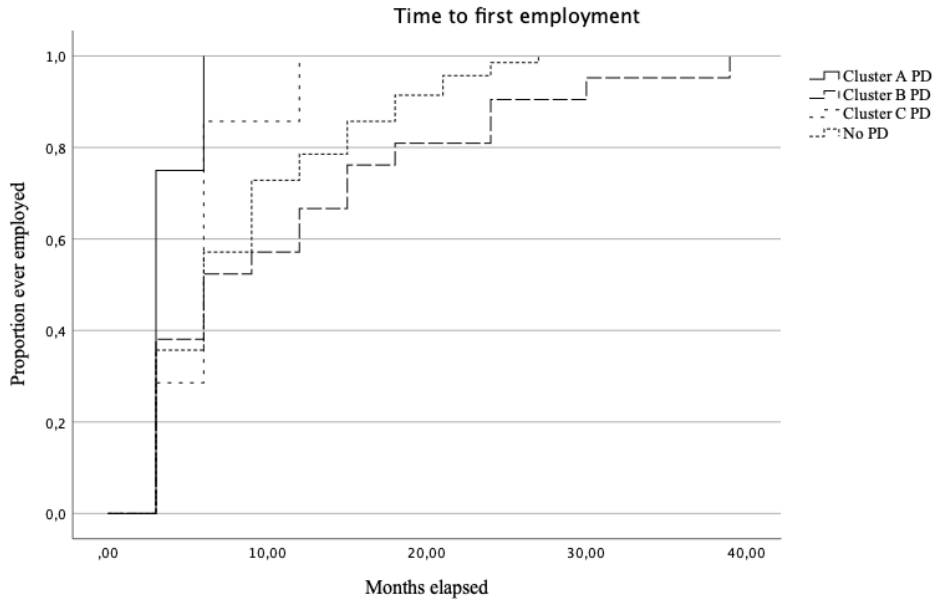
(b) For the other variables, Clusters A and B contrasted with Cluster C and no-PD group. This last pattern was statistically weaker but more recurrent throughout the different variables. Overall employment rate (1/3 versus almost 1/2), rate of people receiving a salary as a main source of earnings (1/5 versus 1/3), mean activity total duration and longest period of activity duration (twice as low) were lower in Clusters A and B than in the other groups. The model for this last finding was very likely.

Among only participants who were ever active within IPS, a third pattern emerged, with the four groups being equal. Activity durations were also slightly lower in Clusters A and B (6 versus 8.5 months) than in the other categories, although no group difference was statistically reported.

The survival curves (Figure 2.2) revealed that participants in Cluster B reached activity significantly slower than all other groups ($p = .04$). All participants in Clusters A and C who found a job within IPS did so within the first year. However, those two groups were very small. It took more than 2 years (27 months) for people in the no-PD group and more than 3 years (37 months) for those in Cluster B to all reach employment for those who did. Moreover, after the first 6 months, overall employment rate was consistently lower for Cluster B than for all other groups.

Figure 2.2

Time to First Competitive Employment for Service Users Who Were Ever Employed During Individual Placement and Support and Not Employed at Baseline



Note. PD = personality disorder. (PD Cluster A, $N = 4$; PD Cluster B, $N = 21$; PD Cluster C, $N = 7$; no PD, $N = 70$).

2.5 Discussion

This study investigated the effectiveness of the IPS model for PD clients. PD clusters and no-PD groups were compared on several vocational outcome variables. Better professional rehabilitation results were expected for no-PD and Cluster C groups than for Clusters A and especially B given their functional impairments (Hengartner et al., 2014; Lang & Hellweg, 2006; Skodol et al., 2002). Indeed, overall employment, last earnings main source and duration of activity were worse for participants in Clusters A and B than in Cluster C and no-PD group.

Time to first employment and last activity type were the worst for participants in Cluster B. Evidence for the latter outcome was quite strong. Cluster B was systematically less successful and differed from the no-PD group. This

corroborates previous research stating that people in Cluster A show work impairments, although to a lesser extent than those in Cluster B (Lang & Hellweg, 2006).

It is surprising that the proportion of people receiving a salary as their main income was lower for people in Clusters A and B, whereas the proportion of competitive employment was lower only for people in Cluster B. This seemingly contradictory finding could be explained by the fact that some participants might be part-time employees; therefore, still receiving social benefits in addition to their income. Additionally, it is possible that some participants receive a salary from their on-the-job training, even though they are not considered competitively employed.

Problems were anticipated to occur for people with PD once employed, as their cognition, affectivity, interpersonal functioning, and flexibility manifestations (DSM-5; American Psychiatric Association, 2015) cause conflicts at work (Baer & Fasel, 2011). This corroborates the fact that Clusters B and C participants were more often professionally active within the last 12 months prior to admission than the other groups. This might be due to their ease of finding a job and a difficulty in keeping it (Baer & Fasel, 2011; Ettner et al., 2011; Hengartner et al., 2014). Yet, duration of activity did not differ between groups, which shows the capacity of people with any diagnosis to sustain an activity once obtained when accompanied in the IPS programme.

However, Clusters A and B had shorter activity durations when taking the whole sample into account. This result cannot be explained by difficulties to maintain an activity or by a different length of time in IPS. Instead, it could be explained by a longer time necessary to reach first employment or by never

obtaining employment. People with Cluster B PD's engagement in socially valued activities, such as work, may not typically stem from intrinsic motivation, but rather from a desire to seek approval (Potvin et al., 2019). This could reduce their opportunities for vocational rehabilitation. In comparison, people with SMI are motivated to engage in professional activities because they seek for meaning in their lives (Black et al., 2019). Moreover, people living with BPD have an unstable self-image, notably resulting in sudden shifts in vocational aspirations (DSM-5; American Psychiatric Association, 2015) and likely leading to regular changes in professional projects, altering these persons' attempts at professional rehabilitation. Finally, interpersonal conflicts described above could hinder IPS job coaches' efforts to place individuals in the labour market. Results regarding Cluster B might be drawn by BPD's associated limitations as it represented a large proportion of this group.

IPS is not conceptually illness oriented (Drake & Bond, 2011). Job coaches are not trained in treating mental disorders. They focus on clients' work impairments and not on their mental disorders. They are not necessarily aware of their clients' diagnoses. This helps combat stigma but could sometimes become an issue. The coaching process of people in Cluster B seems challenging, whereas the usually subsequent jobs sustainment support seems equally efficacious for all groups. Maybe job coaches would benefit from knowing early that their clients belong to Cluster B to adapt their own attitudes toward them.

Finally, Cluster C is indeed associated with the no-PD group, for which IPS success has already been shown (Bond et al., 2019). Service users in those two groups have fewer difficulties regarding work than people in the other PD clusters,

which is consistent with the literature (Hengartner et al., 2014; Skodol et al., 2002). This could explain the equal IPS results between PD and SMI groups found by Juurlink et al. (2020, 2022). Cluster C participants demonstrate traits that are valuable in the job market, such as conscientiousness (Barrick et al., 2001) and fear of negative feedback (DSM-5; American Psychiatric Association, 2015), which might motivate them to follow coaches' advice and function well at work (Hengartner et al., 2014; Skodol et al., 2002). IPS job coaches might emphasise these qualities to improve their self-confidence and introduce them positively to potential employers.

As this study was conducted in one region of Switzerland, it naturally results in place-specific characteristics. Current conclusions might not be transferable to other IPS centres. Also, the distribution of gender and psychotic and anxiety disorders differed between the groups, which could have, to some extent, influenced the results. However, the sample characteristics and the high proportion of comorbid mental conditions in the PD groups are consistent with epidemiological data (Schulte Holthausen & Habel, 2018; Zimmerman et al., 2005). An effect of gender could have been expected as men and women are not equal in the labour market, with men being favoured (World Economic Forum, 2021), notably regarding recruitment (González et al., 2018). However, there was no within-group sex difference in any outcome. We therefore argue that mental condition rather than gender can account for our findings. Additionally, the retrospective database resulted in several limitations. First, diagnoses were based on evaluations of personal psychiatrists who treat clients, yet they were not assessed for the purpose of this research. Second, activity type was reported trimonthly, resulting in less

accurate data than when assessed daily or weekly. However, we do not believe that activity situation is extremely time sensitive. Last, clients' variable length of duration in IPS could have impacted the results. For example, service users participating in the programme for a brief time might have had fewer opportunities to find an activity. Moreover, those quitting IPS immediately after finding a job showed a shorter activity duration although they might have maintained their employment afterward.

Additional prospective and controlled studies should be conducted in other places on IPS's effectiveness for people with PD to avoid the limitations encountered. Studying PD as subgroups (e.g., based on clusters or individual PD diagnoses) might be warranted, as this category is broad and heterogeneous.

2.6 Conclusion

IPS was less effective for participants with PD Clusters A and especially B than for the other subjects. Belonging to Cluster C did not negatively affect clients' course in the programme. Participants from Cluster B required more time to find a job and were less employed at the end of IPS in comparison to other participants. We can confidently argue that IPS may benefit from a reconfiguration for clients in Cluster B, for example, by providing specific training to IPS teams, such as GPM for BPD (Gunderson, Masland, et al., 2018), which includes focus on social rehabilitation, notably through work.

3. Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: A qualitative study[5]

3.1 Abstract

People with SMI face different occupational challenges than those diagnosed with PD. The IPS model of supported employment has been validated for people with SMI but its effectiveness for individuals with PD remains unclear, and the reasons for this potential difference have not been explored. This study aimed to identify differences in IPS practice for clients with SMI and those with PD. Six IPS job coaches were interviewed about their experiences. A thematic analysis was run. More difficulties and facilitators were mentioned regarding clients with PD than regarding clients with other SMI. For both, clients' symptoms were reported to negatively affect their (re)integration into the job market. However, in contrast to that of clients with SMI, the relation between symptoms and IPS success for clients with PD involved difficult behaviours and their negative impact on the relational alliance. In summary, IPS practice seems to be undermined by PD and could benefit from adaptations, such as specific training for IPS teams to help them in managing clients with this disorder.

---

[5] Dunand, N., Seydoux, M., Teixeira Magalhaes, M., Bonsack, C., Golay, P., Spagnoli, D., & Pomini, V. (2024). Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: A qualitative study. *Heliyon, 10*(12), 1–11. https://doi.org/10.1016/j.heliyon.2024.e32955

3.2 Introduction

Mental disorders hamper employment. In Switzerland, half of all recipients of disability benefits qualify due to mental illness (Schuler et al., 2020). Of people with schizophrenia and PD in Switzerland, 80% are unemployed and 50% of those who are employed face problems at work (OCDE, 2014).

Work issues vary according to the nature of the mental disorder. On the one hand, people with SMI (e.g., schizophrenia, severe mood disorder), defined by their chronic characteristic of psychotic or mood symptoms, and high rates of relapse, affecting social and professional functioning, experience difficulties related to their health issues which, notably, results in a high rate of absenteeism (Zimmerman et al., 2010). Working full-time could worsen their symptoms (Marwaha & Johnson, 2005). Public and self-stigma toward their conditions hamper access to work (Corrigan et al., 2012; Marwaha & Johnson, 2004). Finally, they show cognitive impairments, notably regarding executive functioning, which induces poor performance and work quality (Green et al., 2004; O'Donnell et al., 2017).

On the other hand, according to the ICD-11, PD are characterised by problems in functioning of aspects of the self, and interpersonal dysfunction, manifest across a range of personal and social situations in patterns of cognition, emotional experience, emotional expression, and behaviour, that are maladaptive (World Health Organization, 2022). DSM5's definition is similar, attesting of one or more pathological personality traits, and moderate or greater impairments in personality functioning, that are relatively inflexible and pervasive across a broad range of personal and social situations (American Psychiatric Association, 2015). PD used to be classified categorically, but in recent decades, its definition has been

moving toward a dimensional understanding, based on the fact that personality traits are constitutive of each person in a more or less problematic degree, reaching pathological level beyond a certain threshold (Clark, 2007; Skodol et al., 2014; Tyrer et al., 2015; Widiger & Mullins-Sweatt, 2010). PD represents about 12% of the general population (Volkert et al., 2018) and 25 to 92% of the psychiatric population (Beckwith et al., 2014; Kovanicova et al., 2020; Tyrer et al., 2015). Comorbidities are very common for this disorder whether they be disorders within the same category–PD–in 60% of cases (Zimmerman et al., 2005) or other categories of disorders–including those recognised as SMI: About three quarters of people diagnosed with BPD have a comorbid disorder other than PD (Shah & Zanarini, 2018; Zanarini et al., 1998). Nevertheless, people diagnosed with PD have in common that they may struggle more with interpersonal difficulties, impulsivity, work conflicts (often resulting in intentional job loss), dismissals, demotion, and unemployment (Ettner et al., 2011; Hengartner et al., 2014; Sansone & Wiederman, 2013; Sio et al., 2011). PD's typical characteristics of relationship issues, difficulties in admitting one's own mistakes, mood swings, and resistance to instruction are seen as the person's fault in a work setting, unlike those of other psychological disorders that are considered to be illnesses and which trigger compassion. Thus, employers are particularly critical of staff members presenting PD characteristics (Baer & Fasel, 2011).

Work increases the well-being of people with mental disorders (van Niekerk, 2009). Thereby, IPS has been developed to help psychiatric service users to regain and maintain competitive employment. In this time-unlimited intervention, job coaches support clients at every step of vocational rehabilitation,

according to their needs and preferences. IPS is currently the most validated model of supported employment (Frederick & VanderWeele, 2019), particularly for people with SMI, for whom it was originally designed (Bond, Drake, et al., 2012). Only a few studies have explored this model's effectiveness for people with PD, with mitigated results. Juurlink et al. (2020, 2022) were the first researching this matter and found no significant difference in the results between IPS traditional clients and those with PD. However, this study had a small sample size, and the heterogeneity of the PD group could explain the intergroup equality. Whereas Dunand et al. (2023) compared PD groups according to different clusters and found that Clusters A and especially B had poorer outcomes, notably in terms of rate of professional (re)integration into the job market, as well as time to reach employment, as compared to people in Cluster C PD or without a PD. More research is needed to come to precise conclusions (Dunand et al., 2023; Juurlink et al., 2020, 2022). In that sense, Chanen et al. (2020) are currently leading a RCT on the effectiveness of IPS for young people with BPD. Most importantly, the reason for this potential difference in effectiveness remains largely unexplored. The clinical statements of IPS coaches attest to difficulty caring for clients with PD of all types. Still, there is a lack of literature on this topic, except in other settings, where negative attitudes of health care staff toward people with PD (Beryl & Völlm, 2017; Newton-Howes et al., 2008) and psychosocial impairments of this population (Skodol et al., 2002) have been shown, which could explain these individuals' lower rates of success in rehabilitation. As people with SMI do not present the same work-related impairments that people with PD do, and that professionals report more difficulties dealing with individuals living with PD, this study aims to explore

the nature of and contrasts between difficulties IPS coaches face with these two populations, and what solutions to these issues can be considered.

3.3 Materials and Methods

3.3.1 Procedure

We conducted a qualitative study with IPS job coaches at RESSORT, a community network programme for supported employment embedded with the Community Psychiatry Wards of Lausanne University Hospital (Switzerland). IPS was implanted at RESSORT in 2009, has cared for close to 700 clients since then and has a cohort of around 60 service users at any given time. A part of its members has then been trained to the model by a team supervised by the founders of IPS in Montreal (Canada). RESSORT's coordinator was herself trained as an IPS supervisor. Since then, the initial team members internally train co-workers with course material validated by IPS founders. The specificity of RESSORT IPS team is that it is part of the hospital's public services. The treatment team is not directly attached to the service. Instead, anyone diagnosed with a mental illness and being treated by a psychotherapist is allowed to join, and job coaches are in regular contact with them. Compared to IPS standards, it implies that clients from all walks of life can participate, and that the level of required integration of treatment services depends on the goodwill of external psychotherapists. In addition, the model is influenced by Switzerland's economic context, in which the labour market is much less liberal than in the USA, where IPS was created. As a result, this team has a fair fidelity to the original model according to the IPS fidelity scale (Bond, Peterson, et al., 2012). The Research Ethics Committee of the University of Lausanne approved the protocol (number #E_SSP_102020_00008).

3.3.2 Participants

Through our existing collaboration with the service, we invited IPS job coaches from RESSORT in Lausanne, Switzerland, to participate. We aimed to reach data saturation, relating to the point where data repeats itself through interviews (Saunders et al., 2018), and usually emerging between six and 12 participants (Guest et al., 2006). Experience-related research questions–as it is the case in the present study–require small to moderate sample size, in order to maintain the focus on individual experience, whilst obtaining patterns across the data set (Braun & Clarke, 2013). It is the case in the present study which enabled participants to share their personal experiences and reflect on concrete examples encountered in their practice, to enrich our understanding of this new topic. We therefore initially selected six coaches–out of the eight in the team–who agreed to participate and signed informed consent forms, and we reviewed their client cohorts to ensure that they had had recent contact with individuals with both categories of disorders of interest to our study, with the possibility of adding more participants if saturation was not reached. When interviews were conducted, researchers sensed informational redundancy across participants and no more new themes and sub-themes emerged as of the fifth interview. We therefore decided to stop sampling.

In total, we interviewed six White job coaches, including two men and four women, between December 2020 and January 2021. Two of them were nurses, two occupational therapists, one a social worker, and one a psychologist. The average age was 38 years old (range: 31–50), number of years of experience as a job coach was 3 (range: 1–6) and number of years of experience in psychiatry prior to their current job was 8 (range: 0–23). Their average work rate as IPS job coaches was

50% (range: 20–80), with around 15 to 20 clients for a full-time position, of which approximately one third have a PD.

3.3.3 Measures

The second and third authors conducted semi-structured interviews based on a topic guide that included questions about coaches' experience with people diagnosed with SMI and PD (see supplemental material). As this study was exploratory, we decided not to distinguish between different forms of SMI or PD, in order to capture a general idea of the difficulties encountered by IPS job coaches. Moreover, the latter are not trained in specific mental disorders and are not necessarily familiar with the client's precise diagnosis. Besides, studying PD as a whole is consistent with the recent dimensional model of PD, which involves examining a broad factor, referred to as the level of personality functioning, in terms of both self and interpersonal aspects (American Psychiatric Association, 2015). In this view, different PD share common symptoms. For each category of clients successively, coaches were asked (a) what kind of difficulties they encountered, (b) which solutions they implemented or conceived for these issues, (c) if IPS seemed adapted for the population, and (d) if they could consider potential adaptations to the model. To avoid possible order-effect bias or fatigue bias as the interview progresses, known in the field of surveys (Jeong et al., 2023; Rasinski et al., 2012), three participants were assigned to a topic guide addressing SMI first and the other three were assigned to one addressing PD first. For this paper, we mainly focused on the difficulties and solutions mentioned and briefly discussed the adaptability of IPS for different types of disorders.

Interviews took place in the participants' office building and lasted around 1 hour. Interviews were audio-recorded, transcribed, and anonymised. Pseudonyms were assigned to each participant.

3.3.4 Data Analyses

The interviews' content was inductively and thematically analysed (Braun & Clarke, 2013). The first author coded the interviews into meaningful chunks, which were then collated and gathered into codes, from which themes and sub-themes were generated to organise and make sense of the data. Those were reviewed with the second and third authors until consensus, to increase interpretation objectivity. Additionally, the frequencies of each sub-theme and code were reported to describe their representativeness for the sample (Hill et al., 2005). Sub-themes and codes were considered "general" when mentioned by all participants, "typical" when mentioned by five or four participants, "variant" when mentioned by three or two participants, and "rare" if mentioned by one participant.

3.4 Results

Two main questions were answered throughout the dataset: (1) the nature of difficulties IPS coaches face with SMI versus PD clients, which refers to service users' characteristics, symptoms or behaviours, and problems in the relational alliance or with the efficiency of the intervention as the negative outcomes such factors cause, and (2) facilitators IPS coaches report with SMI versus PD clients, defined as strategies used by the coaches to overcome these difficulties, ideas of ways to improve the intervention, and present characteristics in service users that ease the intervention. They are not always available with every client but are

features that greatly help coaches when present. However, in this study, most facilitators were related to the coaches' practice rather than skills of the clients themselves.

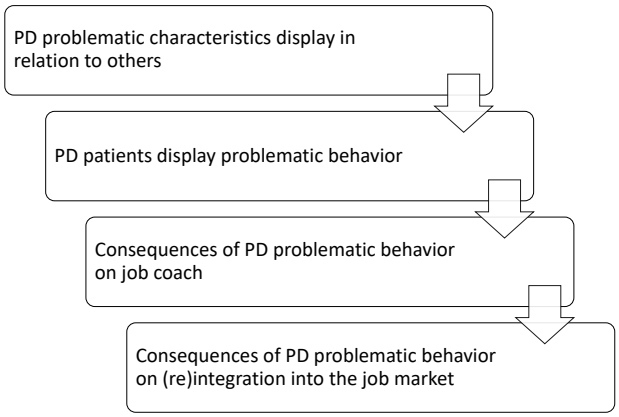
One main finding is that the number of difficulties and facilitators mentioned by the job coaches–as counted as the codes–was considerably higher for people with PD than for those with other SMI. Moreover, many were general and applied to both categories of disorders. In total, 41 difficulties in IPS intervention were identified, of which 25 applied mostly to people with PD, six mostly to people with other SMI, and 10 equally mentioned for both groups. Thirty-one facilitators were identified: 14 mostly for people with PD, three applicable only to people with other SMI and 14 equally shared by both groups. The difficulties were also qualitatively different between the two groups of disorders, which is reflected within the themes and sub-themes.

Question 1: Nature of difficulties IPS coaches face with SMI versus PD clients

Theme 1.1: Difficulties encountered with people diagnosed with PD in IPS intervention are played out in relation to others. The nature of difficulties linked with PD is described in Figure 3.1. They were classified in four inter-related sub-themes. Table 3.1 details their composition.

Figure 3.1

The Nature of and Links Between Difficulties Encountered by Individual Placement and Support Job Coaches When Accompanying Clients Diagnosed with Personality Disorder



Note. PD = personality disorder.

Table 3.1

Sub-themes and Codes of Difficulties Encountered with People Diagnosed with Personality Disorder in Individual Placement and Support Intervention Are Played Out in Relation to Others (Theme 1.1)

Type of difficulty (sub-theme)	Difficulty described (code)
PD problematic characteristic display in relation to others ($N = 6$)	Emotional instability ($N = 5$; i.e. mood swings, impulsivity, disproportionate reactions) Lack of motivation ($N = 5$; i.e., lack of investment in the intervention) Ambivalence ($N = 3$; i.e., splitting, discrepancy between wishes and actions, instability of attitudes toward coaches and professional projects) Comorbidities ($N = 3$; i.e., other disorders diagnosed instead of PD, associated pathologies, disorders arising from PD) Rigidity ($N = 3$; i.e., resistance to change, unsuitability for the demands of the job market) Altered self-image ($N = 2$; i.e., lack of self-confidence, and accuracy of self-worth) Paranoia and sensitivity ($N = 2$; i.e., distrust, sense of persecution, vexation) Over-interpretation [a] ($N = 4$; i.e., misinterpretations, exaggerations, taking things personally) External locus of control [a] ($N = 3$; i.e., deflection and excuses-making)
PD clients display problematic behaviour ($N = 6$)	Interpersonal difficulties ($N = 6$; i.e., lack of social barriers, revenge behaviour, relationship testing, manipulation, perversion, imposition, idealisation, devaluation, maladaptive attachment, lies, disrespect, contempt, dependence, opportunism) Conflicts ($N = 5$; i.e., confrontation, pushing to the limits) Project multiplication ($N = 3$; i.e., dispersal, difficulties following up on one project until the end) Avoidance ($N = 2$; i.e., escaping when change is about to happen, disappearance) Challenged framework ($N = 2$; i.e., intervention setting testing, rules negotiations) Project sabotage ($N = 2$; i.e., refusal to accept help, backtracking when change is about to happen) Triangulation ($N = 2$; i.e., splitting between job coaches and caregivers) Lack of commitment [a] ($N = 3$; i.e., lack of proactivity in the intervention, idealised expectations toward job coaches, difficulty honouring commitments) Missed appointments [a] ($N = 2$; i.e., regular (unjustified) delays and absenteeism)
Consequence of PD problematic behaviour on job coach ($N = 6$)	Fatigue ($N = 6$; i.e., energy-consuming, emotionally involving, feeling of carrying everything on their own, constant work, frustrations) Particularly challenging intervention ($N = 6$; i.e., complicated care) Hypervigilance of the coach's expression ($N = 5$; i.e. particular attention not to upset clients) Mixed feelings about the client ($N = 3$; i.e., interesting work at the same time as negative anticipation before the session because of clients' unpleasant attitudes)
Consequence of PD problematic behaviour on (re)integration into the job market ($N = 2$)	Unemployment and complexity in maintaining professional activity ($N = 2$; i.e., difficulty to keep jobs) Futilely long IPS intervention ($N = 2$; i.e., long care without any outcome) End of IPS without being employed [a] ($N = 2$; i.e., majority of failures to find employment)

Note. PD = personality disorder; IPS = Individual Placement and Support.

[a] Sometimes present in SMI but mostly in PD.

Most difficulties–like emotional lability, ambivalence, rigidity, and their way of perceiving self, others, and events–are associated with the clients themselves and are characteristics of PD. People with PD tend to interpret events in a way that quickly triggers them and affects their mood, which influences the optimal course of the intervention. A participant described all these aspects:

> Normally, the client is also supposed to do things between two appointments, I don't know, for example, a client calls the companies to find out why they haven't been hired. And it's things that weren't being done, when he'd said yes, then he'd say "it's no use, because anyway...". The difficulties were very much projected onto the outside world. "They're all idiots in this company", "there's no point". (Monica)

This results in some problematic behaviours that are also typical of PD, such as interpersonal difficulties, conflicts, challenging boundaries, avoidance, sabotage, and triangulation. A participant gave an example of these behaviours that bring problems into the intervention itself and the job search:

> I had another client who jumped from one project to another. It was hard to stay focused on one. We'd start and all of a sudden, he'd move on to something else because he had an idea in mind, because all of a sudden, he'd say "ah, this isn't working, so I'm moving on to something else". So, it was a bit difficult to keep him focused on what we'd said to each other. (Daniel)

Clients' problematic behaviours negatively impact the relational alliance, and hence their coaches, who must carefully choose their words when interacting with them. They often feel tired of taking care of them, which they found

particularly difficult and unpleasant. This arduous work was illustrated by this participant:

> What is complicated is to always be very attentive to the words chosen, it's quite demanding to always weigh well the use of each word and to feel in what emotional state they are, to see how far we can go in what we say, in what we do, in the demands we make, in the way we give feedback on their behaviour, on what they might have said during an interview or a phone call, or the way to write a letter. (Emilie)

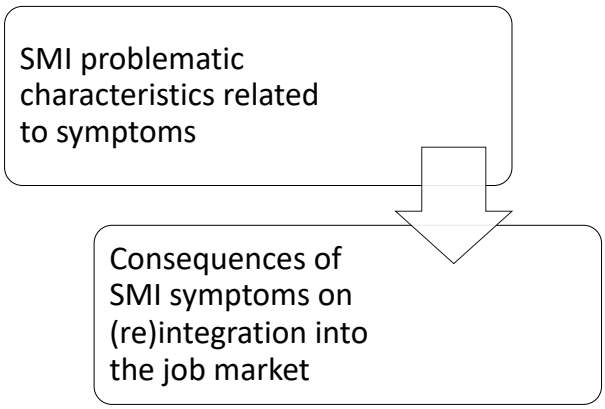
This, in turn, hinders the efficacy of IPS intervention, with long care periods that do not necessarily end in employment. This participant showed how an intervention can last without being productive when clients stay stuck in one orientation that does not seem to work for them:

> Even if we set goals every 3 months, if it's been more than 10 months and nothing has changed and we've always set the same goals because the person didn't want to open up employment opportunities, well, at some point, even if the IPS model says it's good to continue, well, it becomes more difficult for the coach. (Max)

Theme 1.2: Difficulties encountered with people diagnosed with SMI in IPS intervention related to their level of illness. The nature of difficulties linked with SMI is described in Figure 3.2. Its components are visible in Table 3.2.

Figure 3.2

The Nature of and Links Between Difficulties Encountered by Individual Placement and Support Job Coaches When Accompanying Clients Diagnosed with Severe Mental Illness



Note. SMI = severe mental illness.

Table 3.2

Sub-themes and Codes of Difficulties Encountered with People Diagnosed with Severe Mental Illness in Individual Placement and Support Intervention Related to Their Level of Illness (Theme 1.2)

Type of difficulty (sub-theme)	Difficulty described (code)
SMI problematic characteristic related to symptoms ($N = 6$)	Functional limitations ($N = 4$; i.e., disorganisation, attention problems, memory disorders, mistrust, difficulty entering a relationship and communicating, lower work capacity) Anosognosia ($N = 2$; i.e., time needed to realise and accept weaknesses) Unstable health [a] ($N = 4$; i.e., symptom recrudescence, work is not always the priority) Symptom visibility [a] ($N = 2$; i.e., looking odd to others)
Consequence of SMI symptoms on (re)integration into the job market ($N = 4$)	Discouragement in case of failure ($N = 3$; i.e., difficulty staying motivated over the long term in the absence of success) Complexity in the work application process ($N = 2$; i.e., lack of autonomy, organisation, and rigor during job search)

Note. SMI = severe mental illness.
[a] Sometimes present in PD but mostly in SMI.

In comparison with PD, no difficulty described for people with other SMI was general to all coaches. No symptom characterising SMI resulted in problematic behaviours. Rather, these clients are affected by health issues and symptoms, for example, problems in communication, memory, consistency, or organisation. This participant showed such impairment's challenge for finding employment:

> [A client] is particularly very, very, very disorganised, and therefore the slightest task takes him half a day. So, we had to work on this capacity of disorganisation first, which resulted in the fact that within a year and a half of care, we were able to send only three job applications, because within the time he managed to prepare his application, well, the job advertisement did not exist anymore. (Emilie)

The relational alliance is apparently not affected, unlike with people with PD. However, these difficulties have consequences on reaching employment and on both the coach and the client, who become slowly discouraged. One participant explained this discouragement from both sides when no employment materialises.

> When someone with depression is told "no" 20 times, after a while he says, "I don't feel like it anymore." Even you say to yourself, "I don't feel like it anymore," but for a person with depression, it's even worse. (Daniel)

Theme 1.3: General difficulties encountered in IPS intervention for both PD and other SMI clients. General difficulties are less in relation to clients' symptoms than to external constraints. This is shown in Table 3.3.

Table 3.3
Sub-themes and Codes of General Difficulties Encountered in Individual Placement and Support Intervention for Both Personality Disorder and Other Severe Mental Illness Clients (Theme 1.3)

Type of difficulty (sub-theme)	Difficulty described (code)
Professional difficulty (*N* = 5)	Job market (*N* = 4; i.e., competition, job field influences success, influence of candidate's age and career path, COVID-19 resulted in home-office which is not adapted to certain clients) Career path (*N* = 3; i.e., dismissals, gaps in the resume, professional instability, inconsistencies in the career path, poor work certificates) Challenge of practicing job coaching with a psychiatric population (*N* = 3; i.e., finding a job necessarily more difficult when psychiatric symptoms are present)
Health difficulty (*N* = 5)	Crisis (*N* = 3; i.e., suicidal ideation, conflicts with peers, risk being expelled from the country) Negative impact of failure in reaching employment (*N* = 3; i.e, impact on hope, motivation, self-esteem, and self-confidence) Disability (*N* = 2; i.e., lower work capacity)
Coach's difficulty (*N* = 5)	Ending the intervention (*N* = 5; i.e., difficulty assessing when the intervention still makes sense for the client) Admitting that no miracle solution exists for dealing with complex cases (*N* = 2; i.e., even the best strategies and interventions are not always beneficial, some difficulties are out of their hands)
Client's problematic behaviour (*N* = 3)	No career goal (*N* = 2; i.e., absence of goal hindering the possibility of concrete steps toward change) Commitment irregularity (*N* = 2; i.e., clients' motivation and availability fluctuate with life events)

For example, strict requirements of the work market that demand skills, experience, flexibility, or initiative are an obstacle to finding a job. These make the work market difficult to reach in general, and even more in psychiatry. One interviewee explained that IPS participants often aim at jobs in the same field, which makes it difficult to find positions for everyone: "There are certain professions that we accompany a little more in IPS, and these professions are the ones that are a little more of dead-end jobs" (Max).

Some codes are related to the clients' situation, and they affect their professional success but are not described by the coaches as elements that incur difficulties for the coaches in their tasks. This is the case for service users who are going through objectively difficult social events, those who must deal with job rejections, or those who are recognised as disabled, as this participant explained:

> Sometimes they can work at a certain rate [...] but they have a reduced output. [...] Let's say a worker works full time in a factory, that's an example, so they can work at 100%, only they are a little slower [...] so instead of producing a hundred bottles a day, they are going to produce seventy. The bottles will be beautiful, but they won't produce the hundred bottles they're supposed to if they were 100% profitable. (Angela)

On their side, coaches sometimes feel cornered or out of resources when it comes to ending an intervention that is no longer necessarily justifiable with a client for whom no employment perspective seems possible at that stage. They are afraid of shattering clients' hopes. However, these coaches must sometimes accept that no magical solution exists and that certain situations may persist independently of their efforts and goodwill. This participant illustrated the consequences of ending interventions with some clients, showing why it can be so difficult:

> IPS intervention was clearly not possible, but when I had to make the decision to put an end to it, the client did not agree at all, because for him it was really the only thing that kept him going. And since I announced that we were stopping, well, he stopped his medication because for him it didn't make sense to continue taking antipsychotics if there was no prospect of a job. So, he's slowly decompensating because he's no longer medicated. (Emilie)

Coaches described a lack of career objectives and of regular participation in the intervention as the only problematic behaviours that were difficult for their mission and which applied to clients independently of their diagnoses. Indeed, it is common in psychiatry that service users miss appointments and disengage from

interventions. This does not allow for optimal work to arise and therefore deteriorates IPS success. One participant showed their need to always stay proactive to ensure that their client did not disengage from the intervention:

> Sometimes they don't say: "yes, we'll see each other next week," they say: "yes, we can see each other in 3 or 4 weeks," and it's up to us to be a bit vigilant, I think, to keep the focus, and to keep the rhythm. (Monica)

Question 2: Facilitators IPS coaches report with SMI versus PD clients

Theme 2.1: Facilitators of coaches and clients diagnosed with PD in IPS intervention. Most facilitators mentioned in the interviews were related to PD clients. They are visible in Table 3.4.

Table 3.4

Sub-themes and Codes of Facilitators of Coaches and Clients Diagnosed with Personality Disorder in Individual Placement and Support Intervention (Theme 2.1)

Type of facilitator (sub-theme)	Facilitator described (code)
Coach's facilitator with PD (*N* = 6)	Scientific research (*N* = 4; i.e., search of evidence-based strategies and tools) Collaboration with experts (*N* = 3; i.e., collaboration with PD experts for supervision, diagnosis assessments and who could refer them their clients who are ready to work) Communication style (*N* = 3; i.e., being clear and not afraid of naming things) Team discussions (*N* = 3; i.e., team reflections to find strategies) Inclusion of client's family (*N* = 2; i.e., family as extra support) Spontaneous strategies (*N* = 2; i.e., adapted natural attitude rather than planned strategies) Emotional distance [a] (*N* = 6; i.e., avoiding feeling personally overwhelmed by situations) Regular questioning of the added value of IPS for each client [a] (*N* = 4; i.e., set regular goals and their evaluation with the care network to avoid becoming stuck in an intervention that no longer makes sense for the client) Professional experience [a] (*N* = 3; i.e., experience in psychiatry, supervisions) Client's job support [a] (*N* = 3; i.e., importance not to think that support is not needed once on the job) Intervention-time limitation [a] (*N* = 2; i.e., research has shown that few jobs are found by persisting in IPS beyond 9 months) Transparency with client a (*N* = 2; i.e., show honesty and own doubts)
PD skill (*N* = 3)	Ease in starting the intervention and looking for a job (*N* = 3; i.e., relative ease in the process of application) High cognitive skill level (*N* = 2; i.e., fair level of education, comprehension, and intelligence)

Note. PD = personality disorder; IPS = Individual Placement and Support.

[a] Sometimes present for severe mental illness but mostly for PD.

Almost all the facilitators that exist or are possible in interventions with PD clients are strategies set by the coaches. Such strategies rely on various forms of support: from science, experts in the disorder, coaches' teams, and clients' families. PD obviously reinforces the coaches' need for professional community. Coaches also decide to adopt a certain approach toward clients with PD, expressed in the coaches' manner of communicating, distancing themselves, or setting boundaries around the support they can bring. This was reflected in one participant's discourse:

> I reread one of his cover letters and made proposals. In fact, every time I made a proposal, he would justify for three minutes why he had done it that way, etc. In other words, I couldn't offer him anything because his letter was perfect, and he shouldn't have touched it. [...] So I said to him: "Well then,

> fine, we'll leave it like that if you think it's perfect. There's no problem. But my role is to check and try to improve it. For me, by putting these things in, it's improved. If I put myself in the place of an employer, I'd like it to be more like that than like you've done it, which doesn't mean that what you've done is bad. Because as many people are going to read your letter, as many people are going to give you their opinion, I say, but at the same time if I don't give you my opinion, I'm useless". So, then he said “no, no, no, but it's okay, do it”. So, he let me do it, but it took a bit of readjustment. So sometimes, you get into things that are a bit subtle like that, and you have to take it on the fly and then try a strategy that doesn't always work, but that worked, so much the better. (Astrid)

Only two facilitators out of the 13 coaches mentioned in relation to their clients with PD were linked to those clients’ skills. Furthermore, these two facilitators were considered “variant”. As opposed to people with SMI, people with PD were described as able to sell themselves well to find a job and having high levels of intelligence and education; as one participant noted, their clients with PD “are often people who have managed to study quite far, so that’s not going to prevent them from finding a job” (Max).

Theme 2.2: Abilities of SMI clients as a facilitator of IPS intervention. Only a few categories of resources were linked to SMI clients. They are presented in Table 3.5.

Table 3.5
Sub-themes of Abilities of Severe Mental Illness Clients as a Facilitator of Individual Placement and Support Intervention (Theme 2.2)

Facilitator described (code)
Adequate understanding of one's disorder of people with SMI (N = 3; i.e., symptoms recognition and management)
Ease of maintaining a job for clients with SMI (N = 2; i.e., reliable and pleasant workers)
Confronting clients with SMI (N = 2; i.e., let clients become aware of their limitations through their experience and by showing them transparency)

Note. SMI = severe mental illness.

Most facilitators described in IPS intervention for people with SMI were related to those clients' own skills, such as their capacity to understand, anticipate, and control their symptoms or–unlike people with PD–to keep a job, even though finding one is a challenge. A participant explained how this knowledge about one's disorder is an argument that helps present a client to a company as a potential hire: "It's a tool that can also be used with employers, to say: 'he knows his limitations, thus he can anticipate [his reactions]' " (Angela).

Only one variant code related to coaches' strategies. It consists in managing clients experiencing anosognosia by allowing them to reach a certain work rate or work domain with which their limitations are considered incompatible. Thereby, such clients become aware of their weaknesses, which helps them move away from unattainable careers to more suitable ones.

Theme 2.3: General facilitators in IPS intervention for both PD and other SMI clients. General facilitators refer to strategies that coaches (would like to) use to improve the intervention, or to components that are external to both parties involved in the relational alliance, and yet which ease the job coaching. They are shown in Table 3.6.

Table 3.6

Sub-themes and Codes of General Facilitators in Individual Placement and Support Intervention for Both Personality Disorder and Other Severe Mental Illness Clients (Theme 2.3)

Type of facilitator (sub-theme)	Facilitator described (code)
Coach's general facilitator (*N* = 6)	Setting boundaries (*N* = 6; i.e., keep focus on goals) Teamwork (*N* = 6; i.e., well-functioning care network, support of the team and supervisions as resources) Referring clients outside of IPS (*N* = 5; i.e., in case of failure with the model) Inter-individual differences between job coaches (*N* = 4; i.e., different sensitivity, ease and opinion in the team as a strength) Shared responsibilities (*N* = 4; i.e., mutual agreements, empowering clients without burdening them) External sources of support (*N* = 3; i.e., relaxing activities outside of work, personal introspection) Continuous training (*N* = 3; i.e., training about different disorders, suicidal ideation management and more) Meta-communication (*N* = 3; i.e., directly rephrasing what is happening, what has been said with clients, and communicating with colleagues about how they feel) Humour (*N* = 2; i.e., use of humour with the team and the clients, when the alliance allows, to dedramatize situations) Strong alliance (*N* = 2; i.e., enables a beneficial intervention through trust and an adapted mode of communication once established)
Professional facilitator (*N* = 4)	Professional network (*N* = 4; i.e., IPS systematic job development, word of mouth with colleagues and clients' string-pulling) Employers' sensitivity (*N* = 2; i.e., raising awareness about mental illness among employers) Rethinking the job market (*N* = 2; i.e., moving toward a social economy, seeking more help from the government) Strategies in choosing targeted job (*N* = 2: i.e., trying to avoid stressful or dead-end domains)

Note. IPS = Individual Placement and Support.

The first sub-theme of general facilitators was composed of codes like that of coaches' facilitators related to clients with PD. Indeed, all participants valued teamwork–including their colleagues and the added value of each–, supervision, training, collaboration with all other actors involved in the clients' recovery or transferring clients to other institutions when needed. Appropriate opportunities for collaboration were not always present, but the best outcomes were noticed by the coaches to correspond with their "hand-in-hand" work with other professionals. Additionally, coaches chose to implement strategies which entailed specific

behaviours, such as setting clear boundaries, sharing responsibility with the client for the intervention's goal, meta-communicating to avoid misunderstandings or misinterpretations, or using humour both with clients and to put difficulties into perspective with other professionals. One participant explained how they involve clients in decision-making during the intervention:

> I'm going to tell him that we've tried everything, and then what do we do with that, what does he suggest? In a way, give him back his responsibility, and not endorse all that myself–without burdening him either, because he shouldn't feel guilty that we're stuck. (Astrid)

Professional facilitators included the professional network of both the client and the coaches and components of the job market, such as employers' knowledge of and openness to mental disorders, and the professional sectors that were hiring or not. This participant described the lack of awareness about mental health in certain work settings, which makes it difficult to reintegrate clients:

> We went to introduce the IPS programme to the human resources [department] of a big company. And my colleague added, "well, IPS is also a programme for severe psychological impairments," but I think the HR manager immediately said, "but we don't have any employees with severe psychological impairment." I said, "maybe there's someone who works for you at 50% and it's not a choice, it's a question of health, and they work very well at 50%." (Angela)

3.5 Discussion

Results can be addressed from two different angles. Quantitatively, job coaches reported more difficulties working with clients diagnosed with PD than they did for those with other SMI. Further, those difficult experiences with clients with PD were more often shared across the group of job coaches in comparison with those reported for people with other SMI. Paradoxically, more facilitators were also mentioned regarding care with PD clients than with other SMI clients. This could be due to our facilitator concept not only including features that are present but also what helps when present and suggestions for improvement. It is also possible that fewer facilitators are necessary for coaches to successfully work with clients with SMI, while coaches expressed the need to be creative and use support with PD clients. Many of the mentioned difficulties and facilitators were generalised and applicable to all clients, regardless of diagnoses. This could be because the coaches' tasks are similar across their clients and the difficulties they might face and several components they must work with, such as the constraints of the job market, are the same independently of their clients' pathologies. Several of these difficulties were shared by most coaches. Moreover, coaches' attitudes toward their clients and their approaches to practice, which underlie many of the facilitators mentioned, are likely to be their professional ethos, and therefore are similar with all clients.

Qualitatively, coaches reported the same difficulties that are mentioned in the literature. Issues regarding PD clients are more relational (Ettner et al., 2011; Hengartner et al., 2014; Sansone & Wiederman, 2013; Sio et al., 2011), which seems to challenge coaches and impact interventions to a very significant extent.

Difficulties mentioned for people with SMI were more often challenges for the clients themselves, such as managing their own symptoms (Corrigan et al., 2012; Green et al., 2004; Marwaha & Johnson, 2004, 2005; O'Donnell et al., 2017; Zimmerman et al., 2010). This obviously affects the effectiveness of the job coaching but does not seem to particularly challenge coaches and the relational alliance.

Several PD characteristics seem to be externalised as problematic behaviours affecting others (Bailey & Finn, 2020). For example, emotional instability results in impulsivity, which can translate into conflicts, whether these are at work or with the clients' caregivers. A triggering event in a certain context will change the mood of a client with PD and affect other people in other contexts as well. Problems become shared between surrounding people instead of staying at a personal level. In short, PD problems are often large-scale and affect the client's whole environment instead of being internalised and contained, in comparison to those of people diagnosed with other SMI, who are more inclined to experience symptoms defined as internalised (Watson et al., 2022). This might be explained by the fact that people diagnosed with PD have difficulties with self–other distinction (De Meulemeester et al., 2021). Difficulties of people with SMI–such as discouragement–also affect coaches, but the internal conflict is not transferred into the relational alliance. The personal nature of these clients' difficulties makes it easier for coaches to solve them. In comparison, if problems affect others, it adds layers of challenges for coaches, who must manage their own reactions and emotions, those of the other, and those at play in the relational alliance.

In parallel with the identified difficulties, most facilitators mentioned for people with PD come from the coaches while those mentioned for people with other SMI are client related. This does not mean that people with PD lack personal resources. In fact, their extreme traits are often exaggeratedly present qualities, which would benefit from being softened to serve as a strength and be valuable at work and even be highlighted when disclosing a condition to employers. This is the case, for example, with sensitivity, perfectionism, or vigilance, which become problematic only when they are ill-adapted in a context. It would be interesting to identify these traits at the beginning of the intervention and set their mitigation as an agreed-upon target for the job coaching (N. Baer & C. Kirchgraber, personal communication, September 30, 2021). Thereby, IPS would still focus on impairments rather than on a diagnosis.

One of the only personal aspects mentioned as a facilitator for people with PD was their generally high cognitive skill level. This might generate expectations from the coaches, who see such clients as possessing qualities that are valued on the work market, making them forget about the emotional level of disability characterising PD clients, and therefore reducing their tolerance for difficulties that appear during the intervention. This was not pointed out in the interviews. This raises the question of relevance of warning coaches about certain potential biases they could fall into.

This research enabled us to draw a contrast between the SMI and PD populations, and to gather coaches' opinions on the adaptability of IPS to these groups, based on their experience. The suitability of the IPS programme was more often questioned by coaches for people with PD than for people with other SMI,

although this part of our larger dataset has not been covered in the present results. Such uncertainty could seem logical, given the fact that IPS was conceptualised for people with SMI and is not illness-oriented (Drake & Bond, 2011). However, IPS is flexible and should be suitable for, and adapting to any psychiatric population. This clinical statement might be due to coaches' lack of knowledge on how to deal with people with PD. Indeed, the IPS project focuses on work impairments rather than on diagnoses. Coaches are not healthcare providers but social workers, who are not trained in the management of specific mental disorders, as clients' treatment is received outside of IPS. While this helps combat stigma, coaches might not be adequately equipped to support the PD population. Furthermore, some IPS requirements, such as adaptation to clients' wills in terms of career goals and support time length, might even be detrimental for individuals with PD who need more frame (Gunderson, Masland, et al., 2018).

This study completes and supports quantitative results regarding IPS lessened efficiency for people with PD, especially Clusters A (i.e., odd, eccentric) and B (i.e., dramatic, erratic) who seem to reach poorer vocational outcomes regarding employment status, activity (i.e., job or education) maintenance, time before finding a job and type of income (Dunand et al., 2023). Facilitators that are described for people with PD are still compatible with the IPS philosophy and most of them are already being used, which brings reassuring perspectives. Promising ideas of systematic change that could be implemented were mentioned, such as time-limiting the intervention when the support does not help the client–which corroborates the finding that if no job has been started after 9 months in IPS, likelihood of finding employment drastically decreases (Burns et al., 2015)–,

regularly questioning the added value of the intervention, or developing collaborations with PD experts. These suggestions are in line with a set of guidelines of recommended therapeutic practices to accompany people living with BPD, called GPM (Gunderson, Masland, et al., 2018). This evidence-based approach condenses what works in specialised treatment for people with BPD and can be used by mental health professionals from any background. It consists in a general attitude rather than a strictly structured intervention, and therefore can be relevant in different contexts of psychiatry. Like in IPS, GPM is individualised, and work constitutes one of the main intervention goals. GPM could meet the need for structure that IPS lacks, as mentioned above. Several of its recommendations were already spontaneously used by the coaches, such as using their common sense, being transparent, sharing responsibility, or feeling and adapting to their clients' emotional states. One central point of this approach is to practice psychoeducation with clients, which is consistent with the idea of identifying extreme personality traits. In the sense of easing IPS practice to better accompany people with BPD toward employment, it would be relevant to train coaches to the GPM approach, especially given the fact that they mentioned continuous training as something motivating and helpful.

To the best of our knowledge, this is the first qualitative study exploring IPS coaches' perspectives on their interventions. However, the number of participants was limited and, even though we judged saturation to have been reached, this concept remains controversial in the qualitative research literature (Saunders et al., 2018). Again, as IPS focuses on recovery, job coaches do not necessarily have precise knowledge of their clients' mental illness and may, for example, have

mentioned users with comorbid SMI and PD, thinking of the dominant disorder. This also explains why we chose broad categories of disorders to explore the difficulties described by job coaches, with the risk of inducing bias toward groups. Because of this choice, the interviews' topic guide directed coaches to consider people with PD or with SMI in general, without specifying a diagnosis, while we know that a wide range of disorders with their respective issues exist in each category, likely leading to a certain degree of approximation in the participants' responses. We cannot exclude the possibility that coaches answered our questions with some level of stigma they carry about mental disorders. Nevertheless, the interviewers asked participants for specific examples about the clients they had followed in their practice to limit this bias. Finally, this study was led in Lausanne, Switzerland, with its specific job market and situation, and where staff talk about challenges working with people with PD, although this attitude seems to be shared in other healthcare settings (Beryl & Völlm, 2017; Newton-Howes et al., 2008). The authors adopted a reflexive posture throughout the study process, with the aim of reducing possible biases in the co-construction of meanings that such research involves. The first author is trained as a psychologist and works regularly with the job coaches. However, she is independent of the service users' treatment. Analyses were also discussed with other members of the research team, including clinical psychologists, senior research psychologists and a senior psychiatrist, as well as at interdisciplinary meetings comprising clinicians, researchers, peer-practitioners and service users. The question of the extent to which the results can be generalised to all IPS teams remains open.

3.6 Conclusion

IPS practice seems to be undermined by PD. The relational alliance seems to be affected when working with clients with PD, compared with those with SMI. Therefore, we can confidently argue that adjustments in IPS should primarily be made for PD, such as specific training for IPS teams to care for people with the disorder as soon as they enter the programme. For example, the implementation of GPM for BPD (Gunderson, Masland, et al., 2018) could be considered for implementation in the IPS context. A recent implementation study shows promising results in this regard (Dunand, Golay, et al., 2024).

6

[6] SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

4. Good Psychiatric Management for borderline personality disorder: A qualitative study of its implementation in a supported employment team[7]

4.1 Abstract

People with BPD have difficulties with work. The IPS model has shown its worldwide effectiveness in terms of vocational rehabilitation for individuals with psychiatric disorders. However, only a few recent studies have explored its results for people with PD, and the findings were mitigated. Additionally, IPS job coaches reported difficulties in supporting this population. An evidence-based psychotherapeutic method, also applicable in a case management context, called GPM for BPD, could potentially overcome these obstacles. This study aimed to evaluate the initial integration of GPM in IPS practice. IPS practitioners of Lausanne University Hospital, Switzerland, were trained in GPM in January 2022. Five of them participated in a focus group to collect their impressions about the training, and six were interviewed 9 months later to assess the initial adoption of GPM into their practice. Thematic analyses were conducted. Job coaches were positive about this new tool. All of them found it useful and beneficial both for them and their clients. They were able to follow the main GPM principles in their practice. However, the findings also suggested some additional improvements in

[7] Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (2024). Good Psychiatric Management for borderline personality disorder: A qualitative study of its implementation in a supported employment team. *PLoS ONE*, *19*(3), 1–14. https://doi.org/10.1371/journal.pone.0299514

the implementation process. Integrating GPM in IPS seems feasible, and the team who appreciated it adopted it. The method offers new perspectives in community support for people living with BPD.

4.2 Introduction

People with PD, especially of the borderline type, show work-related dysfunctions such as interpersonal difficulties, impulsivity (Sio et al., 2011), a low education level, work conflicts, which often result in losing a job on purpose (Sansone & Wiederman, 2013), dismissals, demotion, and unemployment (Ettner et al., 2011; Hengartner et al., 2014). Moreover, employers are critical towards staff members with relationships issues, difficulties in admitting their own mistakes, mood swings, and resistance to instructions, which people with PD often convey (Baer & Fasel, 2011).

To help people with mental illness in their professional rehabilitation, the IPS model (Becker & Drake, 1993) of supported employment has shown worldwide efficiency (Frederick & VanderWeele, 2019). It consists of job coaches accompanying service users to work and helping them to maintain their job, adapting to their needs and preferences for as long as they wish. The goal is to rapidly access the competitive work market, defined as regular paid job available to everyone. IPS participation is open to anyone receiving treatment for a mental illness. Job coaches collaborate with healthcare teams and develop connections with the job market.

However, IPS model was conceptualised for people suffering from SMI (Bond, Drake, et al., 2012). Those refer to disorders that persist over time and are prone to relapse and recurrence such as schizophrenia and chronic mood disorders (Shinnar et al., 1990). Only few recent studies have explored IPS effectiveness for people with PD, the results of which were not conclusive. One of them showed no difference between traditional IPS clients and those with a PD but cited the small

sample size and heterogeneity of the PD groups as possible explanations for this result (Juurlink et al., 2020, 2022). To avoid the issue of heterogeneity, Dunand et al. (2023) studied the IPS population with PD divided into the DSM-5 clusters (American Psychiatric Association, 2015). They notably found that people in Clusters A and especially B had a lower rate of professional reintegration and a slower time to reach employment than people with a PD in Cluster C or with disorders other than PD. Also, IPS principles consistency with guidelines for treating people with PD is questionable. The latter advocates more structure than IPS, which is time-unlimited and focuses on clients' preferences. Furthermore, as professionals in other clinical settings, notably with medical, nursing and social work background (Newton-Howes et al., 2008), IPS job coaches report more difficulties in their practice when encountering people with this disorder. This shows the necessity for adapting IPS to people with PD.

An evidence-based therapeutic method, GPM for BPD (Gunderson & Links, 2014) is currently being expanded. It is based on best practices recommended by the American Psychiatric Association (2001) for the treatment of BPD. It consists in flexible guidelines of attitudes to adopt when facing individuals with this condition. Its basic principles are to offer psychoeducation, not overreact, be cautious, value the relationship, convey that change is expected, foster accountability, maintain a focus on life outside of treatment and be pragmatic. A RCT showed that its effects and lasting characteristics on service users equalled those of DBT (McMain et al., 2009, 2012). These results should be interpreted with caution given that research on the topic is scarce. Service users who fail to respond should be advised to follow specialised treatments. Nevertheless, GPM is effective

for most of them and covers basic training of mental health professionals. It is recommended not only in therapy contexts but also in case managers' practices (Drozek, 2019). Therefore, it could be considered a potential additional feature that could be relatively easily integrated into the IPS programme, without underestimating the cost in time and resources of incorporating new elements into one's practice. Evidence indeed shows that a one-day training in this approach already increases practitioners' comfort with and interest in working with persons living with BPD (Keuroghlian et al., 2016; Masland et al., 2018). Moreover, GPM and IPS share common values and practices, such as clients' empowerment, focus on vocational integration, use of common sense, importance of setting goals and multimodality of treatment.

Therefore, this study aimed to assess through a qualitative study the initial integration of GPM for BPD into IPS practice. We hypothesised that this integration would be successful in terms of feasibility, acceptability, appropriateness, adoption, and fidelity, as based on Proctor et al.'s (2011) outcomes for implementation research.

4.3 Methods

4.3.1 Design

This study was conducted at RESSORT, a community network programme for supported employment from the Community Psychiatry Wards of Lausanne University Hospital–including three centres: Lausanne, Prangins and Montagny-Près-Yverdon–and Nant Foundation (Switzerland). IPS was implanted at RESSORT in 2009. A team that the founders of IPS supervised in Montreal

(Canada) then trained a part of RESSORT's team members on the model. RESSORT's coordinator was trained as an IPS supervisor. Since then, the initial team members internally train co-workers with course material that IPS founders validated. The specificity of the RESSORT IPS team is that it is part of the hospital's public services. The clients' treatment team is not directly attached to the service. Instead, anyone suffering from a mental illness and being treated by a psychotherapist is allowed to join, and job coaches are in regular contact with them. In addition, Switzerland's economic context, characterised by higher educational standards, fewer entry-level jobs, and difficulty laying off workers, influences the model as compared to the labour market in the United States, where IPS was created. As a result, this team has fair fidelity to the original model according to the IPS fidelity scale (Bond, Peterson, et al., 2012). Due to the above-mentioned particularities, the items that received the lowest ratings included the contacts between IPS team and the treatment team, the rapid start-up of job searches, and the creation of links with the job market. IPS job coaches care for around 15 to 20 clients for a full-time position, of which approximately one third have a PD.

For this study, all 12 IPS job coaches from RESSORT were trained to use GPM for BPD. They received a half-day training, which took place online due to the COVID-19 pandemic-related measures in January 2022. The content was based on Gunderson and Links' (2014) manual and adapted to IPS practice. The training was dispensed by the first author, who had herself been trained by GPM specialists. Since then, they benefit from an ongoing monthly group supervision by an expert in the GPM approach. According to Proctor et al. (2011), implementation outcomes

should include the service at different stages. Therefore, qualitative data were collected at two timepoints in RESSORT with IPS job coaches.

4.3.2 Sample

The research team offered job coaches from RESSORT to participate voluntarily in this study. They were recruited through existing collaborations within our psychiatry service between the 20th of January 2022 and 13th of December 2023. All participants signed written informed consent forms. The Human Research Ethics Committee of the Canton Vaud approved the project (protocol # 2021-01362).

We conducted a focus group with five job coaches, who came forward to take part in the study, including four women and one man. Two of them were nurses, one an occupational therapist, one a social educator, and one a psychologist. The average age was 43.8 years (range: 30–60), number of years of experience as a job coach was 3.1 (range: 0–7), and number of years of experience in psychiatry prior to their current job was 13.4 (range: 3–25). Their average work time as IPS job coaches was 70% (range: 20–100%).

Regarding number of individual interviews, we aimed at reaching saturation, usually emerging between six and 12 interviews (Saunders et al., 2018). In total, we interviewed six female job coaches, two of whom had participated in the focus group. Two participants were psychologists, two social workers, one an occupational therapist, and one a social educator. They were selected as they showed an interest in participating. The average age was 38.2 years (range: 30–43), number of years of experience as a job coach was 3.5 (range: 1–8), and number of

years of experience in psychiatry prior to their current job was 5.3 (range: 3–11). IPS job coaches' work on average at 76.6% (range: 50–100%).

4.3.3 Procedure

A focus group and individual interviews of around one hour were conducted with the job coaches in their office building to collect participants' opinions about the integration of the GPM training for their practice. They were audio-recorded, transcribed, and anonymised.

The first author led the focus group 6 weeks after the GPM training to obtain their initial thoughts as a group about the relevance of the collective training soon after attending it. Their opinions about the integration of GPM in their practice, its benefits and limitations, its compatibility with IPS, how they thought it would modify their practice, and what would be their needs for an optimal implementation were asked through semi-structured questions (see topic guide in the supplemental material).

The first author and a graduate psychology student conducted each semi-structured interview around 9 months after the GPM training to assess individually the change in their practice, and more specifically, the implementation's relevance, acceptability, feasibility, adoption, and fidelity (Proctor et al., 2011). The topic guide concerned change in their practice that potentially emerged following the training, its benefits, limitations, which principles they did or did not adopt, to which extent they found GPM compatible with IPS, and the relevance of implementing this training on a larger scale (see supplemental material). During

both the interviews and the focus group, job coaches were presented with GPM and IPS principles on a sheet to help them discuss their relevance and compatibility.

4.3.4 Data analyses

A thematic analysis (Braun & Clarke, 2013) was performed over the focus group and individual interviews' content. It consisted of finding sense by reorganising data according to emerging topics. Each interview portion could be coded more than once. Parts of the interview that did not answer the research questions were not coded. The first author coded the focus group and the individual interviews of clients, and, to increase interpretation objectivity, a graduate psychology student helped with coding the entire data set of coaches' individual interviews. Content was segmented into meaningful features, which were then collated and gathered into themes and codes. When analysing the sixth interview, because no more new code was generated and the entire data set converged into identical themes, saturation was assumed to have been reached and sampling stopped. Additionally, the frequency of participants mentioning each theme and code helped determine the section's representativeness for the sample (Hill et al., 2005). A fragment was considered "general" when all the participants mentioned it, "typical" when five or four participants mentioned it, "variant" when three or two participants mentioned it, and "rare" if only one participant mentioned it.

4.3.5 Researchers' reflexivity

We adopted a reflexive attitude during the research process to reduce possible biases in qualitative studies of the coconstruction of meaning, with the aim of preserving the authenticity of participants' discourse. The first author is trained as a psychologist and works regularly with the job coaches. However, she is not

involved in the clients' treatment within or outside the present research context. Analyses were discussed with other team members, including senior research and clinical psychologists, and a senior psychiatrist, as well as during interdisciplinary meetings comprised of clinicians, researchers, peer practitioners, and service users. The codes and themes were reviewed together in the light of some interview quotes. The researchers' assumptions and analyses were presented, and other team members then examined whether other interpretations of the same data could be plausible. The conceptualisation of the project and the interpretation of results were discussed several times. What emerged from these discussions was taken into account in the final work.

4.4 Results

The implementation assessment results are displayed in two parts: (a) according to the team soon after the GPM training, and (b) according to the team 9 months after training. In each part, themes follow elements of success, satisfaction, dissatisfaction, and prospects of improvement. Themes and subthemes related to positive attitudes were generally more developed than the ones regarding negative aspects.

Part 1: Service implementation outcomes soon after the GPM training

Table 4.1 displays results of the discourse analysis of the focus group that took place with job coaches a few weeks after participating in the training. Four themes have been highlighted, all general in terms of representativeness of the sample.

Table 4.1

Analysis of Individual Placement and Support Job Coaches' Discourse Regarding the Integration of Good Psychiatric Management Few Weeks After Training

Themes	Codes
Positive impact of the GPM training in the context of IPS ($N = 5$)	Useful tool ($N = 5$)
	Relevant reminder to take care of the beginning of the intervention ($N = 4$)
	Interesting principles ($N = 4$)
	Elucidation of spontaneously applied principles ($N = 3$)
	Compatibility with RESSORT ($N = 3$)
	Structure ($N = 3$)
	Expected benefits for clients ($N = 3$)
	Practice assessment allowance ($N = 3$)
	No detrimental aspect ($N = 2$)
	Adaptation of IPS to BPD clients allowance ($N = 2$)
	Solution to the difficulties ($N = 2$)
Lacks in the training ($N = 5$)	Need for contacting clients' former employers not addressed ($N = 4$)
	Motivation problems not addressed ($N = 4$)
	Problems in setting an intervention goal not addressed ($N = 3$)
	Work capacity-related problems not addressed ($N = 3$)
	Full adaptation of IPS to BPD clients not allowed ($N = 2$)
	Swiss economy-related problems not addressed ($N = 2$)
Conditions to apply GPM ($N = 5$)	Care network collaboration necessary ($N = 5$)
	BPD diagnosis necessary ($N = 4$)
	Need for discussion times after the training to integrate GPM ($N = 4$)
	Need for financial resources for optimal implementation ($N = 2$)
Negative aspects of the GPM training in the context of IPS ($N = 5$)	Incompatibility with the role of job coach ($N = 4$)
	Additional workload ($N = 3$)
	Difficulty in automatically applying GPM principles in practice ($N = 3$)
	Incompatibility with certain IPS principles ($N = 2$)

Note. IPS = Individual Placement and Support; GPM = Good Psychiatric Management; BPD = borderline personality disorder.

The first theme, being the one containing the most codes, gathers the positive points of the training according to the job coaches. This includes an interest in the tool and principles presented; the recognition of aspects already present in their practice, hence, GPM compatibility with the service; its advantages for both users and providers; and its relevance for assessing the intervention. A participant described the benefits of the training as being a reminder of good practices to use with clients with BPD.

> We must be vigilant when we enter the relationship because we know that this is what is very important, and to frame and perhaps even anticipate the

> intervention and put in place (...) an action plan that is a little more defined, formalised, personalised, in order to anticipate the moments when it will be more difficult. So, for me, it's true that it was really a little alarm bell that told me to be careful, to really put care into everything and to be very vigilant. (Job Coach 2)

The second theme regards what the training lacked in terms of remaining issues in the team's practice that GPM cannot address. The codes all relate to challenges that job coaches face and are difficult to address. Although not all participants mentioned each of them. It included clients' recurring reluctance to respond to the need for the job coaches to contact clients' former employers to gain a better understanding of their situation, the lack of motivation, clients' professional plan and work capacity, the impossibility to adapt fully IPS to the BPD population, and the limitations of the labour market. This last issue relates in particular to protection against dismissal in Switzerland, which does not encourage employers to give applicants a chance to try, unlike in the United States where the IPS model originated. The following participant notes the difficulty of clients' refusal to provide access to their former employer's contact information as a persistent impediment to an optimal intervention that is addressed by neither IPS nor GPM.

> The barrier also that I see maybe–it's true that it's valuable if you can contact former employers. And in case they refuse, I think it's complicated, and especially in the case of a PD, I think you have to know a bit how.... Okay, maybe relationally it's complicated but what was complicated, how did it happen...? (Job Coach 5)

Several conditions were mentioned as being required to apply GPM principles. This constitutes the third theme, which is driven by the idea that close collaboration with the client's care network, a recognised BPD diagnosis, discussion times for the team (informally within intervisions and supervisions), and the service's financial resources are needed for optimal implementation. This is reflected in a participant's discourse praising the benefits of intervisions for their practice as well as the importance of involving clients' care networks for improving the intervention effectiveness.

> Intervision remains the best form of continuous education; It's the culture of exchange. In our profession, without exchange, you become poorer. That's clear. In addition, with this type of people or profiles [...], it can call into question your professional identity, your doubts. It's true that sometimes you waver too, you see, so there's always this work of distancing to be done– relationally, being too close, too far away, and so on–so the third party of the colleagues, or of the group, regulates, and then brings some material to the prevention of oneself, to save one's energy. It's important and it seems essential to me. (Job Coach 4)

The last theme gathers the negative aspects of GPM the job coaches listed. It is the less representative theme as it is composed of only four codes from which none are general to the whole sample. GPM incompatibility with the job coach role was noted. They feared being put in the place of a therapist rather than a job coach, notably with psychoeducation. In addition, three participants raised the negative vision of this implementation as extra work, and the difficulty to automatise the use of the tools in their practice. Compatibility between GPM and some IPS principles–

time-unlimited support and priority to clients' preference–was also questioned. In the following quotation, where a participant was asked whether GPM and IPS were compatible, the participant answered that GPM was going against the IPS principle of time-unlimited support through its incitement to frame an intervention and assess its usefulness for continuing, notably depending on the client's engagement. However, this IPS infringement seemed helpful when working with people with BPD.

> Clearly, if you take the die-hard principles of IPS, well, no. Because if you really take IPS at its core, it's, "we'll support you until there's no more need." Now, with these people, it's an unlimited need [...] So it could help us frame, yeah, all of that, with empowerment and so on. (Job Coach 1)

Part 2: Service implementation outcomes 9 months after the GPM training

Job coaches' perspectives about the implementation 9 months after their GPM training appear in Table 4.2. The main themes are the same as the ones present in the focus group, with an additional one regarding progress margin in the implementation, which could obviously not emerge right after the training. All themes of Part 2 were general except the last one, which was typical.

Table 4.2

Analysis of Individual Placement and Support Job Coaches' Discourse Regarding the Integration of Good Psychiatric Management Nine Months After Training

Themes	Codes
Positive impact of the GPM training in the context of IPS (*N* = 6)	Principles' adoption (*N* = 6) Promotion of comfort and skills (*N* = 6) Supporting supervisions (*N* = 6) Usefulness for other disorders (*N* = 6) Generalisable training in psychiatry (*N* = 6) Mostly useful for people with borderline personality disorder (*N* = 6) Compatibility with RESSORT (*N* = 5) Serenity in the client's care (*N* = 5) Personal comfort beneficial for the client (*N* = 5) Ease of implementation (*N* = 5) Usefulness of all GPM aspects (*N* = 5) Compatibility with IPS (*N* = 4) Appropriate training content (*N* = 4) Direct application after training (*N* = 4) Better understanding of the disorder (*N* = 3) Compatibility with clients (*N* = 3) Ability to follow individual's preferences while still providing structure (*N* = 3) No change required in the training (*N* = 2) Appropriation of tools (*N* = 2)
Lacks in the training (*N* = 6)	Inevitable persistence of certain difficulties (*N* = 6) Existence of complementary tools (*N* = 3)
Conditions to apply GPM (*N* = 6)	Regular theoretical reminders necessary (*N* = 5) Exchanges between professionals necessary (*N* = 5) Borderline personality disorder diagnosis necessary (*N* = 4) Practical application necessary (*N* = 4)
Negative aspects of the GPM training in the context of IPS (*N* = 6)	Incompatibility with certain IPS principles (*N* = 5) Limitations to offer psychoeducation in IPS (*N* = 4)
Progress margin for the implementation (*N* = 5)	Room for improvement in good practices (*N* = 5) Ideas for improving the training format (*N* = 5) Ideas for improving the supervisions format (*N* = 4)

Note. IPS = Individual Placement and Support; GPM = Good Psychiatric Management.

The richer theme of this part is the positive effect GPM has on the team. It shows how most GPM principles were adopted in the IPS programme, how it helped the job coaches feel more comfortable in their practice, and how this positively affects the clients. They also found GPM compatible with their initial practice and would recommend the generalisation of the training in other spheres of psychiatry. It is possible to see this, for example, in a participant's discourse.

> Typically, in this situation, everything went like clockwork, even though he was the most temperamental client I had. So yes, I think being clear, naming

> things, and being prepared, with an eye steeped in the training we've had, helps a lot, really a lot. Because before, I know there would have been a huge reaction, whereas by doing that, it allows you to anticipate, it allows you to prevent, it allows you to communicate better; There's no ambiguity. So, it sounds silly like that, but I wouldn't have done it before. […] Because it's about saying things, being as clear as possible. And that helps enormously in this type of care because there is no room for interpretation, there is no room for triangulation, for splitting. In any case, it avoids this kind of thing. So, I find it more comfortable since the training. (Job Coach 6)

The second theme is about what the training lacks in the sense that GPM cannot overcome all aspects of what can arise in IPS practice. Clients will always face difficulties when a job coach cares for them. Additionally, GPM alone is not the only tool that allows job coaches to feel more comfortable and it is not meant to replace all types of treatment modalities. Notably, one participant described this.

> Good treatment requires client adherence. And if you don't have that, even the best PD psychiatrist who has a good success rate with those who adhere, well, it's not going to work. That's why I say that the training, the content, is good; I found it very good. At the same time, there are other independent variables that can play a role. (Job Coach 1)

The third theme aroused the idea that GPM was applicable only under certain conditions, including the necessity of theoretical reminders, practical application of this theory, a space to discuss cases, and the presence of an official BPD diagnosis. One participant explained how important regular reminders about good practices were important for their work with people with BPD.

> I find that, unfortunately, with borderline clients, even if we think we know, we always need a reminder to be able to cope during the intervention, to be able to maintain the framework, [and] to meet the clients' needs. (Job Coach 3)

Yet, the team shared some negative aspects of the training, notably that it was going against a few IPS principles, and that psychoeducation, being a key element of GPM, was not the job coaches' role. One participant explained why the IPS principle of competitive employment as a first goal was not always advised for individuals with BPD.

> Normally, that's the request. In reality, given that there are things that have been experienced as a failure, that have been destabilising, emotionally hurtful for these people, sometimes, lowering the professional stakes and tending towards experiences that are going to be more reassuring, containing, perhaps not in the competitive work market, will have, in my opinion, a constructive impact on them for the future […]. In fact, what we are aiming for is duration, sustainability; so I allow myself to readjust things so that a foundation of trust is established for the person and for the intervention. That's the only way to move the relationship forward. (Job Coach 2)

The last theme relates to the progress margin for a more successful implementation. It includes the improvements the job coaches can make towards better practices–the principles they need to integrate further–, but it also includes suggestions to improve the training and associated supervisions. One participant confessed she still had difficulties not overreacting to what the client provoked,

which is a key principle of the GPM approach. However, we still saw her motivation to improve this point.

> I'm still overreactive. That's the whole point of continuing to train not to be. Or less, at least. (Job Coach 2)

4.5 Discussion

To the best of our knowledge, this is the first qualitative study investigating the use of GPM in an IPS context with service providers at two time points. The implementation of a training for good practices for BPD in a supported employment setting was assessed soon after the training and 9 months later, and the main attitude seemed positive. Quantitatively, there were more themes and codes on the positive side than on the negative one, and participants less often shared the latter.

Feasibility or practicability can be considered reached because, soon after the training, job coaches described GPM as compatible with their practice, and that several theoretical points were elucidations of the way they were already working. After a few months, they described an ease in implementing GPM principles. However, according to them, this application was possible only under some circumstances, such as a well-functioning care network collaboration and the presence of a BPD diagnosis, which are largely encouraged within GPM theory. These requirements do not only fall under the coaches' responsibility, but the latter do have some latitude to bring progress, such as involving the first-line therapist more, as it should be a condition for IPS participation. Some coaches in this study even suggested imposing collaboration with clients' psychotherapists.

Acceptability, which the expression of the job coaches' satisfaction can assess, was high. Directly after the training, they found GPM theory interesting, and after a few months, they felt more comfortable and skilled. They were also positive about the method of implementation: They notably appreciated assisting group supervisions even though this could have been seen as an extra burden. Nevertheless, they sensed potential issues soon after the training: the additional workload the integration induced, as well as the expected difficulty in automatising the use of new tools. However, these matters are not negative points about the combination of GPM and IPS per se, and they were no longer mentioned after a few months of practice.

Regarding appropriateness or suitability, soon after the training–this opinion persisted after a few months of practice–the job coaches saw a use for GPM. They recognised its advantages and benefits in their work with people living with BPD. They found it adapted to other clients too. In that sense, they suggested systematising the GPM practice in other psychiatric contexts. No detrimental aspect was mentioned. Compatibility with their clinical model of practice was recognised, except regarding some IPS principles, which they felt like they were violating by following the GPM approach. In fact, it depends on IPS theory's interpretation: IPS and GPM principles can coexist. IPS values clients' professional project preferences while people with BPD tend to come regularly with new goals–due to BPD clients' self-image instability notably marked by shifts in vocational aspiration (American Psychiatric Association, 2015)–hampering the likelihood of any project to materialise. However, IPS does not state that job coaches should follow service users through ever-changing goals. With GPM principles in mind, it is possible to

support the client according to their preferences with enough frame to keep this goal in mind and to avoid repetitive deviations. This is precisely what half the job coaches raised during the interviews. Similarly, there was a seeming contradiction between the IPS principle of time-unlimited support and GPM-framed intervention. It is again the interpretation of IPS principles that causes confusion because job coaches could theoretically continue supporting clients as long as it makes sense for them. However, IPS does not affirm that the intervention should continue when there is no more sense to it. Instead, job coaches ought to use their common sense and end the intervention if it is not helping. GPM specifies principles that already exist. Job coaches also noticed an incompatibility of GPM with some features of their professional function. This is exactly why GPM theory argues for multimodality of treatment, so that each practitioner avoids going beyond their role. Furthermore, psychoeducation, for example, was not always mentioned in its exact definition during the interviews. It is indeed not the job coach's role to educate service users fully about their disorder, but they can talk about BPD clients' functioning related to work, for instance. Moreover, all job coaches mentioned offering psychoeducation as one of the adopted principles, which shows they all practiced it to some extent.

Adoption, or uptake of the GPM assets into IPS practice, occurred according to the job coaches. After 9 months of training, they reported applying the principles, feeling more comfortable and skilled, and having integrated the tools that spread through their professional style. Yet, they noted that an improvement margin still existed to be able to affirm truly that they fully practiced GPM, which was not surprising at this stage.

Fidelity was defined as the adherence to GPM. Again, after a few months of training, job coaches revealed applying most principles. However, job coaches stated several issues: remaining difficulty in setting goals with unstable clients and the need for a functioning collaboration with the client's network, which depends not only on them but on mutual will. In addition, as mentioned, it seemed to them that it was impossible to follow GPM principles and some IPS principles simultaneously. However, IPS, being a flexible model, is subject to interpretation. With a critical view, it is possible to be faithful to both models simultaneously. In addition, IPS in its classical form did not seem to be adapted to the BPD population (Dunand et al., 2023); Therefore, it is expected to deviate from the conventional principles to achieve better effectiveness.

The job coaches mentioned some of what the training lacked, including issues that were indeed not addressed by GPM, which was not originally designed for supported employment and cannot include every specific matter of each modality of treatment involved in a client's path towards recovery. Nevertheless, we believe that some of these concerns are subject to improvement, and with the right tools, the job coaches could address them, such as the use of motivation-based approaches. Larson (2008) suggested coupling supported employment with motivational interviewing. This would require resources and more evidence but is an interesting avenue. Job coaches could also focus on defining an intervention goal until they become more comfortable with this task. This could fall into other aspects that coaches mentioned as margin of progress for them. Conversely, some of the job coaches' concerns are rather independent of their tasks, such as navigating low work capacities or the constraints of the Swiss economy that leaves little

opportunity for less efficient workers. Some level of difficulties is also unavoidable: Service users' health still depends more on psychotherapeutic work than on the job coaches who are not meant to be in the first line or in charge of treatment. Furthermore, even though GPM is applicable and good enough for most service users, some of them will still need BPD-specialised therapies to evolve positively (Gunderson & Links, 2014).

To support the present results, qualitative and quantitative data were also collected with people with BPD participating in IPS at RESSORT (Dunand et al., accepted). We aim at analysing if the attitude of trained job coaches translates into clients' satisfaction and better success in terms of professional reintegration. The following step would then be to compare IPS effectiveness with and without GPM-trained job coaches in a RCT, and then work on the implementation methodology to generalise the use of GPM in other teams.

A limitation of the study is that almost all participants were women. However, this is representative of RESSORT team and social professionals in general (National Health Service, 2021). Also, the sample size for both the focus group and the interviews was limited, and despite our assessment indicating saturation, this concept continues to be a controversial issue within the qualitative research literature (Saunders et al., 2018). One potential bias is that the same person gave the training who also conducted the focus group and interviews with job coaches, which could have induced a will to please the trainer in giving positive feedbacks. Aware of this possible issue, the authors adopted a reflexive posture, and the analyses were discussed with several team members. Furthermore, no objective data was collected from job coaches to assess adherence to GPM as in the

study by Kolla et al. (2009), attitude as did Keuroghlian et al. (2016) and Masland et al. (2018), or competence, for example. Finally, this study was led in Vaud, Switzerland, and the results may not generalise to all IPS teams.

4.6 Conclusion

Through the IPS team, this study shows the feasibility, acceptability, appropriateness, adoption, and fidelity in implementing GPM practices in the IPS model. Indeed, job coaches were mostly positive about this feature. They all demonstrated their interest and the added value of such an intervention, which constitutes a reinterpretation of IPS principles rather than a real alteration of the model, notably regarding the focus on clients' preferences, support time limitation, and psychoeducation about work limitations. Improvement ideas include the method of implementation as the integration of GPM in IPS does not seem to contain any theoretical barriers. Among other elements, it would be beneficial to encourage more care network collaboration, which are both significant features of IPS and GPM approaches, emphasise the ways to combine IPS and GPM during the training, increase the intervention frame's clarity with clients–which could all be addressed during supervisions–, reinforce supported employment teams' fidelity to the IPS model, which is a major component for supported employment success (Corbière & Lanctôt, 2011), or suggest the use of motivation-based approaches (Larson, 2008) as an extra feature. However, these results are promising and should be tested further in the hope to increase IPS effectiveness for individuals living with BPD.

5. Good Psychiatric Management for borderline personality disorder in supported employment: A multiple case study of clients' experiences[8]

5.1 Abstract

People with BPD often present occupational issues. The IPS model has shown its worldwide effectiveness in professionally reintegrating people with SMI. Its value for individuals with PD remains largely understudied. IPS job coaches find it difficult to deal with people with this type of disorder. GPM for BPD, an evidence-based therapeutic method, applicable in any psychiatric setting, could be a solution in easing job coaches' practices and reaching more satisfying results for clients. In a previous study, IPS teams seemed to find this additional feature appreciable and feasible. The aim of this multiple case study was to explore clients' experiences of the IPS intervention with GPM-trained job coaches. IPS practitioners of Vaud, Switzerland, were trained in GPM in January 2022. Six of their BPD clients then took part in research interviews addressing their opinion on the intervention. Abductive content analyses were conducted. In parallel, quantitative data from these clients were collected at three timepoints. Their evolution through time was analysed descriptively and linked to their discourse in

[8] Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (accepted). « Good Psychiatric Management » pour le trouble de la personnalité borderline dans le cadre du soutien à l'emploi : Étude de cas multiple sur l'expérience des clients [Good Psychiatric Management for borderline personality disorder in supported employment: A multiple case study of clients' experiences]. Annales Médico-Psychologiques.

a multiple case study. Service users were globally satisfied with the intervention and would recommend it. Judging by the discourse and evolution of the participants, the intervention seemed to help them in their recovery and professional goals. They suggested some additional improvements. The integration of GPM in IPS is appreciated not only by the providers but also by the users. These first results seem promising for the professional reintegration of people living with BPD. The present conclusions should be confirmed through larger-scale controlled studies.

5.2 Introduction

PD, particularly borderline, are associated with occupational dysfunctions. They often experience relationships issues, impulsivity (Sio et al., 2011), a low education level, work conflicts, often conducting to the voluntary loss of their job (Sansone & Wiederman, 2013), dismissals, demotion and unemployment (Ettner et al., 2011; Hengartner et al., 2014). Company managers are particularly intolerant to employees showing PD symptoms, such as interpersonal difficulties, issues in admitting their own mistakes, mood swings and resistance to instructions (Baer & Fasel, 2011).

The IPS model of supported employment aims at coaching people with mental illness, for as long as they need, to reintegrate the competitive work market, according to their needs and preferences. Its effectiveness has been internationally confirmed (Frederick & VanderWeele, 2019). IPS was conceptualised for people with SMI (Bond, Drake, et al., 2012) but welcomes people with any psychiatric disorder to participate. Only few recent studies have tested the model with PD clients with mitigated results (Dunand et al., 2023; Juurlink et al., 2020, 2022). Moreover, IPS job coaches testify of more difficulties caring for this population as compared to others. This difficulty was found by other clinical professionals from different settings too (Newton-Howes et al., 2008). This supports the need to find adjustments to the IPS intervention to better benefit the care of people with PD.

GPM for BPD (Gunderson & Links, 2014) is an evidence-based therapeutic method (McMain et al., 2009, 2012), which can be used in any psychiatric context, such as therapy, or case management (Drozek, 2019). Training IPS job coaches to this method could be an easy solution to their struggles. A day of training is

sufficient to show improvements in health professionals' attitudes towards people with PD (Keuroghlian et al., 2016; Masland et al., 2018). A complementary study shows that the integration of GPM in IPS is feasible and that the job coaches are adopting GPM principles (Dunand, Golay, et al., 2024). However, implementation must not only be assessed with service providers, but also by examining clients' outcomes, including symptomatology and satisfaction (Proctor et al., 2009, 2011). The aim of this study was therefore to explore, using a mixed methods multiple case study approach, the effect of the intervention for persons living with BPD being cared for by job coaches trained in GPM.

5.3 Methods

5.3.1 Design

This study took place at RESSORT, a community network programme for supported employment embedded with the Community Psychiatry Wards of Lausanne University Hospital and Nant Foundation (Switzerland), where IPS was implanted in 2009. IPS job coaches treat around 15 to 20 clients for a full-time position, of which approximately one third have a PD.

For this study, the 12 IPS job coaches from RESSORT were trained to use the GPM for BPD. They received half a day of training which took place online due to the Covid-19 pandemic related measures in January 2022. Since then, they benefit from an ongoing monthly group supervision by an expert in the GPM approach.

We decided to conduct a multiple case study as our question was explanatory. We wanted a naturalistic understanding of how the GPM was being

implemented and received, and what could be improved (Crowe et al., 2011). As it is difficult to determine what falls under IPS alone or IPS in association with GPM, it was important to collect an in-depth comprehension of clients' experience in order to capture the boundary between GPM and IPS (Yin, 2009). We used mixed-methods to approach the issue from different angles and develop a holistic vision of the phenomenon (Mason, 2002).

5.3.2 Sample

Recruitment of BPD clients following the IPS programme started on the 2nd of May 2022 at RESSORT and is still ongoing for quantitative data. The preliminary data presented in the current paper was collected until the 11th of August 2023. The Human Research Ethics Committee of the Canton Vaud approved the project (protocol # 2021-01362). All participants signed written informed consent forms. All BPD clients enrolled in the programme were identified and their job coaches were requested to individually offer them to participate, against remuneration of 30 Swiss francs. They were therefore at different stages of the IPS intervention.

In total, six BPD clients participated in the study: five women and one non-binary person. Pseudonyms were assigned to each participant. The average age was 32.0 years old. Table 5.1 gives some context for understanding clients' situation at the time of the interview. Estelle and Simon started the IPS programme before the training to GPM of their job coach, respectively 10 months and 5 months before. Lynette and Annick enrolled in IPS a month after the training of their job coach and Virginia and Celeste 5 months after the training.

Table 5.1

Clients' Situation in Individual Placement and Support Programme at the Time of the Interview

Client's pseudonym	Age (years)	Number of months of enrolment in the IPS programme
Estelle	24	20
Simon	34	15
Lynette	33	9
Annick	50	9
Virginia	22	8
Celeste	30	5

Note. IPS = Individual Placement and Support.

5.3.3 Data collection

Semi-structured interviews with clients of around one hour were conducted by the first author at the participants' place or in the office building, according to their preference. They took place around 9 months after the GPM training of the team.

The topic guide consisted in questions about their satisfaction with the intervention, and the assessment of GPM principles' application in their experience of IPS. We asked questions about the general history and experience of their care, the alliance with their job coach, the concrete effects of the intervention in terms of professional reintegration and knowledge about their illness, and finally, about their global satisfaction with the programme (see supplemental material). Interviews were audio-recorded, transcribed, and anonymised.

As IPS and employment have also shown to improve symptoms and quality of life in psychiatric populations (Bejerholm & Eklund, 2007; Bond et al., 2001; van Niekerk, 2009), the clients' outcomes completing the interviews included vocational and non-vocational measurements, which are also important features to test as part as an implementation study (Proctor et al., 2009, 2011). Quantitative assessments took place at three different timepoints: at study entry (pre-test), and

after respectively 3 months and 9 months (post-test). We collected routine data at RESSORT regarding clients' work rate and diligence in the programme (rate and cause for cancelled appointments) at 3 months and post-test; activity type at each timepoint: (a) competitive employment, (c) internship, or (c) no activity; time before first employment; and interruption to IPS (time and cause; not necessarily a dropout as IPS time is not defined) at post-test. REDcap questionnaires for assessing BPD symptoms (BSL-23; Bohus et al., 2009; Nicastro et al., 2016) were sent by email to participants at pre- and post-test, and satisfaction with the intervention (STTS-R; Oei & Green, 2008) at post-test. A questionnaire was sent by email to their job coach at 3 months and post-test regarding client's work readiness (WoRQ; Potkin et al., 2016). All the questionnaires are part of the supplemental material.

5.3.4 Data analyses

An abductive thematic analysis (Braun & Clarke, 2013; Thompson, 2022) was performed over the interviews' content using the NVivo software. Like inductive analysis, this method involves first reorganising the data according to the topics addressed, in order to make sense of them. Each interview fragment may be coded several times or not at all if it does not answer the research questions. Content is segmented into meaningful features, which are then collated and assembled into codes, sub-themes, and themes. The abductive method is particular at this stage as the themes are conceptualised using existing theories to explain the findings. In the case of this study, the themes correspond to the characteristics of a successful GPM intervention (Gunderson & Links, 2014). The use of a conceptual framework allows to generate knowledge that can be transferable to other clinical contexts and inform

the reasons for successful or unsuccessful implementation (Crowe et al., 2011). Additionally, the frequency of participants mentioning each theme, sub-theme, and code helped determine the section's representativeness for the sample (Hill et al., 2005). A portion was considered "general" when all the participants mentioned it, "typical" when mentioned by five or four participants, "variant" when mentioned by three or two participants, and "rare" if mentioned by one participant only. Clients' quantitative outcomes were descriptively analysed.

5.3.5 Researchers' reflexivity

A reflexive attitude was adopted by the authors during the research process, to avoid the common pitfalls of qualitative studies and preserve fidelity to the participants' message. The first author is trained as a psychologist and works with the job coaches. However, she is independent of the clients' treatment. Analyses were discussed with other research team members, including senior research and clinical psychologists, and a senior psychiatrist.

5.4 Results

Client's reactions to the intervention are displayed in three parts, as suggested by Crowe et al. (2011). First, a summary of participants' individual IPS history is given. Next, cross-cases analyses of the interviews are presented. Finally, links to the descriptive statistics are established.

Part 1: IPS path

Estelle had just started a full-time job in IT support when she entered IPS. She had an apprenticeship diploma in this field but was expecting to change careers, although she was ambivalent and indecisive about what she wanted to do: another

training or a new job and in which area. In the past, she had had several negative professional experiences, particularly with regard to working conditions, poor team relations, and weariness. She enjoyed the atmosphere at her job, and her employers and customers were satisfied with her work. However, she was experiencing ups and downs, questions about her romantic life, and a lot of fatigue. She therefore decided to reduce her work rate to 70% after 7 months. This relieved her tiredness, but her new financial situation caused her new worries. After 1 year in IPS, she received a BPD diagnosis from her psychiatrist. This helped her understand her states. After 2 years in the same job, she decided to resign and look for a new one. At the time of the interview, she was positive as she looked back at this experience. She was in her last weeks in this position.

Simon lived alone. They have an apprenticeship diploma in retail management and worked in this field for 4 years. They also have a diploma in assistant management but have never worked in this area. They then held short-term jobs and internships in social work. When they entered IPS, they wanted to change careers, as they did not appreciate being in contact with customers, and social work was too emotionally demanding for them. They were volunteering in an organisation that helped people in precarious situations, and maintained this activity throughout the duration of IPS intervention. Their professional project was directed towards administrative work. They were also receiving reintegration assistance from the Invalidity Insurance Office. After 6 months of enrolment in IPS, they received the BPD diagnosis. At the same time, they obtained a 3-month internship as a receptionist in a company specialised in mortgage financing. This gave them a high level of motivation. They had good relationships with employers

and colleagues. However, for economic reasons, the internship did not lead to a permanent position, which Simon found very unfair and discouraging. Their mental health has deteriorated; They missed IPS sessions. By the time the interview took place, Simon had decided with their job coach to end the IPS intervention as they no longer felt ready to work in the competitive labour market.

Lynette had been diagnosed with BPD for several years. She lived alone and had little entourage. She has an apprenticeship diploma as a socio-educational assistant, but had never worked in this field. She had tried various vocational readaptation programmes, not specialised in mental disorders, without success. When she joined IPS, she was eager to find a job in her field but felt that she needed to start with an internship as she had not practiced for several years. Highly committed, she applied for several positions and obtained several job interviews. Her mental health was stable, even if her family situation was conflictual. At the time of the interview, she was about to start a one-month internship at a 60% work rate in her target field. The internship was subsequently extended for a further 7 months.

Annick worked for 30 years as a medical secretary, but had been laid off twice. She received a BPD diagnosis 7 years before entering the IPS programme. It took her 3 years to accept this diagnosis, but once she understood it, it helped her on her road to recovery. She found adapted coping strategies and support. She had been in a stable and supportive relationship for 15 years. She had been on disability benefits for 4 years. Three months after enrolling in IPS, she had found a job in her field. Her biggest challenge was maintaining an activity. She emphasised her need to find a position adapted to her limitations. She indeed lost this new job after 6

months, and did not understand this decision, which negatively affected her mental state. However, she directly found another position. This shows her acquisition of a great capacity for resilience. The interview took place just between both contracts.

Virginia had started but not completed an apprenticeship diploma in sales. She enjoyed the programme but faced challenges managing her emotions in the workplace. She had been diagnosed with BPD a year prior to the interview and a few months before engaging in IPS programme. At the beginning of her recovery journey, she was still struggling with emotion regulation. Upon entering the IPS intervention, she lacked a clear professional project. Although she expressed interest in pursuing a new apprenticeship, she remained indecisive about the field. Collaborating with her job coach, they aimed to explore various job opportunities through internships. Virginia secured a social integration internship while occasionally engaging in short-term internships in the competitive labour market. However, her mental health remained unstable, marked by anxiety regarding transportation, family conflicts, and self-destructive tendencies.

Celeste holds an apprenticeship diploma as an administrative assistant and has previously worked in short-term positions, though she encountered interpersonal issues and anxiety. Seeking assistance, she enrolled in the IPS programme to secure and maintain employment within her field. She first aimed to rebuild confidence and skills through internships. A month later, she discovered she was pregnant, which brought some anxiety that she effectively managed. She had overall developed adaptive coping mechanisms for handling emotions and was maintaining a stable relationship since 7 years. Due to her pregnancy, she opted to work as a babysitter for a few months instead of pursuing a long-term job. She

rapidly found a position and began additional training in HR in the meantime. Consequently, she decided to withdraw from the IPS programme, as it no longer aligned with her short-term life plans, intending to return after her maternity leave as she valued the support it offered.

Part 2: Qualitative interviews

Two themes have been highlighted, both general in terms of representativeness of the sample. The first one relates to aspects that define a successful GPM intervention, while the second shows the aspects that need to be improved to characterise a successful GPM intervention according to Gunderson and Links (2014). Six subthemes were generated for each theme, mirroring each other, one with a positive connotation, the other one more negative. Themes and sub-themes related to positive attitudes were more developed than the ones regarding negative aspects. Table 5.2 displays all the codes we created from the clients' discourse, organised according to the themes and subthemes in which they fall.

Table 5.2

Codes From Borderline Personality Disorder Clients' Discourse Regarding Individual Placement and Support Intervention with Good Psychiatric Management-Trained Job Coaches

Sub-themes	Theme 1: Successful intervention according to GPM theory (*N* = 6)	Theme 2: Room for improvement of the intervention according to GPM theory (*N* = 6)
Building a stable environment (*N* = 6)	Crisis management strategies (*N* = 6) Use of strategies to avoid problems at work (N = 6) Positive work experiences (*N* = 6) Motivating intervention (*N* = 6) Stability of the disorder (*N* = 5) Valuable support of the intervention (*N* = 5) Importance given to professional role (*N* = 5) Hope (*N* = 5) Knowledge about BPD (*N* = 4) Use of negative experiences as lessons (*N* = 4) Importance of being diagnosed (*N* = 4) Reassuring support of the intervention (*N* = 4) Awareness of one's interpersonal hypersensitivity functioning (*N* = 4) Framing intervention (*N* = 4) Ease in finding employment (*N* = 3) Desire of autonomy (*N* = 3) Motivation to reintegrate into the workplace (*N* = 3) Long-term consolidation of support received (*N* = 3) Stabilising intervention (*N* = 3) Long-term personal learnings (*N* = 3) Being diagnosed improves closed ones' knowledge about the disorder (*N* = 2) Valuable support from closed ones (*N* = 2) Vague memory of the concept of interpersonal hypersensitivity (*N* = 2)	Lack of crisis management strategies (*N* = 5) No disorder improvement during the intervention (*N* = 5) Limitations hampering job retention (*N* = 4) Motivation fluctuations depending on successes and failures (*N* = 4) Apprehension of starting out in the unknown (*N* = 4) Unawareness of the concept of interpersonal hypersensitivity (*N* = 4) Difficulties in impulsivity management (*N* = 4) Disabling symptoms (*N* = 3) Career instability (*N* = 3) Frequent absenteeism at work (*N* = 3) Unrealistic expectations (*N* = 2) Idealisation of the professional project (*N* = 2) Hope leading to disappointment (*N* = 2)

Contractual alliance (*N* = 6) defined as the interventions framework, in terms of roles and goals, that are agreed between the client and the job coach early in the intervention (Bordin, 1979)	Clear intervention goal (*N* = 6) Regular evaluation of the intervention's usefulness (*N* = 6) Specialisation of IPS in psychological disorders (*N* = 4) Support towards professional reintegration (*N* = 3) No fixed time limit of the intervention (*N* = 3) Presence of a crisis plan (*N* = 2) Planned implementation of a crisis plan (*N* = 2) Needs assessment at the beginning of the intervention (*N* = 2) Little homework (*N* = 2)	Little recollection of IPS presentation (*N* = 3) Absence of a joint crisis plan (*N* = 3) No regular redefinition of goals (*N* = 2)
Benefits (*N* = 6) versus limitations (*N* = 3) of multimodal interventions	Care network collaboration as an asset (*N* = 6) Satisfaction with psychotherapy (*N* = 5) Helpful group approaches (*N* = 4) Presence of a care network (*N* = 3) Effectiveness of psychotherapist (*N* = 3) Complementary help from other organisations (*N* = 2) Diagnosed during the intervention (*N* = 2)	Limited communication with the care network and relatives (*N* = 3)
Working alliance (N = *6*) defined as the gradual motivation and engagement in assignment of tasks, coming from both sides during the intervention (Bordin, 1979)	Shared responsibility (*N* = 6) Effective support towards professional reintegration (*N* = 5) Attendance in the intervention (*N* = 5) Positive attitude towards IPS flexibility (*N* = 4) Homework assigned by the job coach (*N* = 3) Clarification of the work project (*N* = 2) Realistic information conveyed by the job coach (*N* = 2)	Fluctuating commitment (*N* = 5) Lack of self-empowerment (*N* = 3) Stagnation in the intervention (*N* = 3) Lack of motivation to participate in the intervention (*N* = 2)

Satisfaction with the supported employment intervention (N = *6*) versus difficult professional reintegration (N = *5*)	Recommendation of the intervention (*N* = 6) Positive attitude towards the intervention (*N* = 5) No detrimental aspect to the intervention (*N* = 5) Added value compared to other interventions (*N* = 4) No aspect to improve in the intervention (*N* = 3)	Unjust dissatisfaction of the line manager (*N* = 5) Working conditions requirements (*N* = 5) External factors hindering professional reintegration (*N* = 5) Intervention ineffectiveness (*N* = 4) Problematic line manager (*N* = 4) Absence of job placement proposal in the intervention (*N* = 2) Psychological stability necessary to participate in IPS (*N* = 2)
Strong (N = *6*) versus weak (N = *4*) relational alliance defined as mutual bond, affect and empathy from both individuals involved in the intervention, which should have developed by 6 months (Bordin, 1979)	Positive relational alliance with the job coach (*N* = 6) Listening job coach (*N* = 3) More informal support than psychotherapy (*N* = 2) No pressure generated by the job coach (*N* = 2) Acceptance of help (*N* = 2)	Negative attitude towards the job coach (*N* = 3) Difficulties in communicating negative aspects to the job coach (*N* = 3)

Note. GPM = Good Psychiatric Management; BPD = borderline personality disorder; IPS = Individual Placement and Support.

The first sub-theme showing positivity in the intervention includes parts of the clients' discourse where they described the building of a stable environment. This covers the stability of their symptoms, knowledge about their disorder and how to cope with it, and a positive attitude towards life, work, and the help the intervention supplies, as mentioned in the following quotation:

> It is true that I have never lasted as long as I did in this job. I usually quit a job after 6 months. So 2 years is not bad. It's true that [the intervention] helped a lot in the framework, well in the general framework of the job, plus all the support I had on the side, etc. It's true that I was relatively well surrounded, so it allowed me to stabilise myself in my work and to hold on. But it's true that before, I managed quite well the first 6 months and after that, not so much. (Estelle)

The second sub-theme is related to signs of contractual alliance with their job coach: the presence of clear intervention's framework, purpose, and tools. For example, this participant illustrated the breadth of job coaches' scope of action:

> She [the job coach] was more than professional, even phoning the unemployment office when I wondered if I had enough months of contributions. I was trying to calculate. One time we sat down together, and she did the calculations with me, she called the unemployment office twice, yes yes, she really got involved. (Celeste)

Third, the benefits of multimodal interventions, promoted by GPM, were underlined. Collaboration within the care network and satisfaction with the complementary help of other professionals were raised. A participant with past

negative experiences with other professional reintegration programmes described how helpful the care network collaboration was in the context of the IPS intervention:

> In comparison with [the placement agency], the first time I went there, there was no collaboration with my doctors. So my first reintegration was a bit of a mess. The second time it was better because they took the psychotherapist into account, but with RESSORT [IPS] it was even more natural to get in touch with my psychotherapist. (Lynette)

The constitution of a working alliance between the client and the job coach is the fourth sub-theme. The sharing of responsibilities, acknowledgment of the support of the job coach and diligence in the intervention are all signs of the collaboration of two individuals towards a common goal. This client was well conscious of the role she had to play in the intervention's effectiveness and recognised the support of her job coaches at the same time:

> We share responsibility 50-50. Actually, for me it's more like 80 and for [the job coaches] it's more like 20, because I'm the one who has to look for my apprenticeship. Then we both do the work. But the day I have to present myself to an employer, it's just me. Me and only me. But it's true that [the job coaches] help me a lot. (Virginia)

General satisfaction with the intervention has been highlighted by clients who would all recommend it and did not notice negative sides of it. Notably one participant found the programme the best reintegration solution she has experienced so far:

> I went through a lot of different structures. And let's say that [...] I find RESSORT [IPS] to be suitable, really much more in terms of care and the way they treat the people they treat. It's really, it's quite adapted. There are certainly other structures that are also adapted, but let's say that from what I know, I find that they are better because there is really care because there are [health professionals]. It's much more varied than in some places where they are going to be adapted to certain things and not to others, and as a result, since they are not adapted to other things, they will direct us to other places and as a result, we will not have one structure, but we will be full of small structures, whereas here, there is only one structure. (Lynette)

Finally, the relational alliance between the clients and their job coach seemed to be present. Participants were positive about their relationship with the job coach, they saw qualities in them and accepted their help. This is visible in the following quotation showing a solid and trusting relationship where it is possible to refocus on the goal of the intervention without hurting the client's feelings:

> Sometimes, I tend to go off in all directions and [the job coach] knows how to gently put me back on track. […] Yesterday I had to spill my guts because I really wasn't feeling well, so she listened to me, she acted as my shrink yesterday. And then at the end she said to me "but you know, we have to start slowly, I'm here, I listen and there is no problem"... So she knows how to […] listen to me when I need it, but she also knows how to gently hand over to me what she is mandated to do, in the end it's the reintegration. But she does it very gently. (Annick)

Sub-themes supporting need for improvements in the intervention according to the users follow the same criteria of GPM intervention success assessment in their reverse end. The first one illustrates clients' difficulties in building a stable environment, that is characterised by a lack of symptoms and crises management skills, of improvement of their health thanks to the intervention, of knowledge about their functioning, of consistency in their motivation to work, and the persistence of work-related problems. We see in this client's discourse that she did not feel armed yet to manage potential difficulties at work:

> Well, what can be a bit complicated already is that, for example, a simple example, an employer who would start yelling at me, and I would take it too much to heart and I would go into a tailspin, or I would scarify myself or I don't know what. And that's not going to work in my favour, it's not going to do it during the apprenticeship, and I don't want that. That's why I'm trying to stabilise myself but it's very, very complicated. And when I get anxious, I don't know how to react. For example, I had an internship as a painter in construction, there was a man who approached me and everything, I was uncomfortable and that made me feel bad and I didn't know how to react because on the one hand I don't know how to say no, on the other hand I'm in an internship. And I think to myself, I will be badly seen so I will have a bad paper and it is not what we want so it is very very complicated. [...] Afterwards, I turn in on myself and I smoke a lot. [...] Yes. I never asserted myself. That's what's so complicated. I'm someone who used to, when I was in a crisis, I would bang my head against the wall. For example, if I want to do a job where there are people, I could never start banging my

> head against the wall in front of people, even my boss would never accept that. I wouldn't be able to keep up with the apprenticeship and that's not what I want. (Virginia)

The second sub-theme describes a threatened contractual alliance with the job coach. Some clients were not able to remember what had been told to them about the IPS programme when they entered it, no joint crisis plan had been filled out, and the goals of the intervention were not regularly redefined, as recommended according to the GPM. This client, as half of the participants, could not recollect what methods were agreed to be used during the intervention:

> No, I don't remember. I don't remember whether we talked about it or not. (Estelle)

Third, collaboration between the care network and relatives was sometimes limited, which is a recognised condition for optimal treatment of BPD. An inconsistency in the messages conveyed by different members of the care network and its negative impact on the client is well illustrated by this participant:

> Both had a different discourse. That is to say that [the job coach] told me "you wait for this gentleman from HR to call you to see what he is going to tell you" and so on. And my doctor told me "it would be good if you called tomorrow to get more information, because I don't understand what they mean". He told me "I have seen many emails from HR, but I have no idea what they mean". [...] And so I had both, one telling me to wait and the other telling me to call. So I woke up Friday morning, I was not feeling well at all because I didn't know what to do. (Annick)

The working alliance was also at risk regarding certain aspects, as motivation and commitment into the intervention as well as self-empowerment were unstable. Also, half of the participants mentioned a feeling of stagnating despite the provided help of the IPS programme. This participant was demotivated and disappointed in seeing the method of work of their job coach who would not be able to answer all their questions directly:

> And they tell you "yes, but you have to look on the Internet". Well yes, but I come to have an interaction and everything and, well I don't know, I find that it's not cool because here we are, we walk people around, then we say "well we have to get information, it's going to take x amount of time", we waste time. There were times when I didn't want to do any research. And yeah, the fact of waiting, waiting... Yeah. (Simon)

Professional reintegration is difficult in itself. Clients talked about problematic managers, requirement towards the work market such as wages' amount, external factors bringing difficulties when looking for a job, as being pregnant or not being able to drive a car for example, ineffectiveness of IPS in professionally reintegrating clients, and the necessity of a certain level of mental stability to properly participate in the programme. A service user explained their delicate situation of not being financially able to study, which in turn hamper their professional reintegration:

> I had explained to [the job coach] that I had no motivation to undertake studies or training given the purchasing power that we have, the salaries that we have and compared to what we pay. I explained to [the job coaches] that I was already surviving, so if I have to spend x amount of time training, plus

> I have to pay back my debts to the government, plus of course surviving, yeah living, well that's going to be expensive. And I don't see why I should bother thinking about it, saying ah, I have to do this as training blah blah blah. In fact, it made me more anxious than anything else. (Simon)

Finally, the relational alliance was also threatened, with the half of the participants describing some negative attitudes towards their job coach and their fear to communicate them. A participant explained that she disliked her job coach at first, which shows that the relational alliance takes time to build:

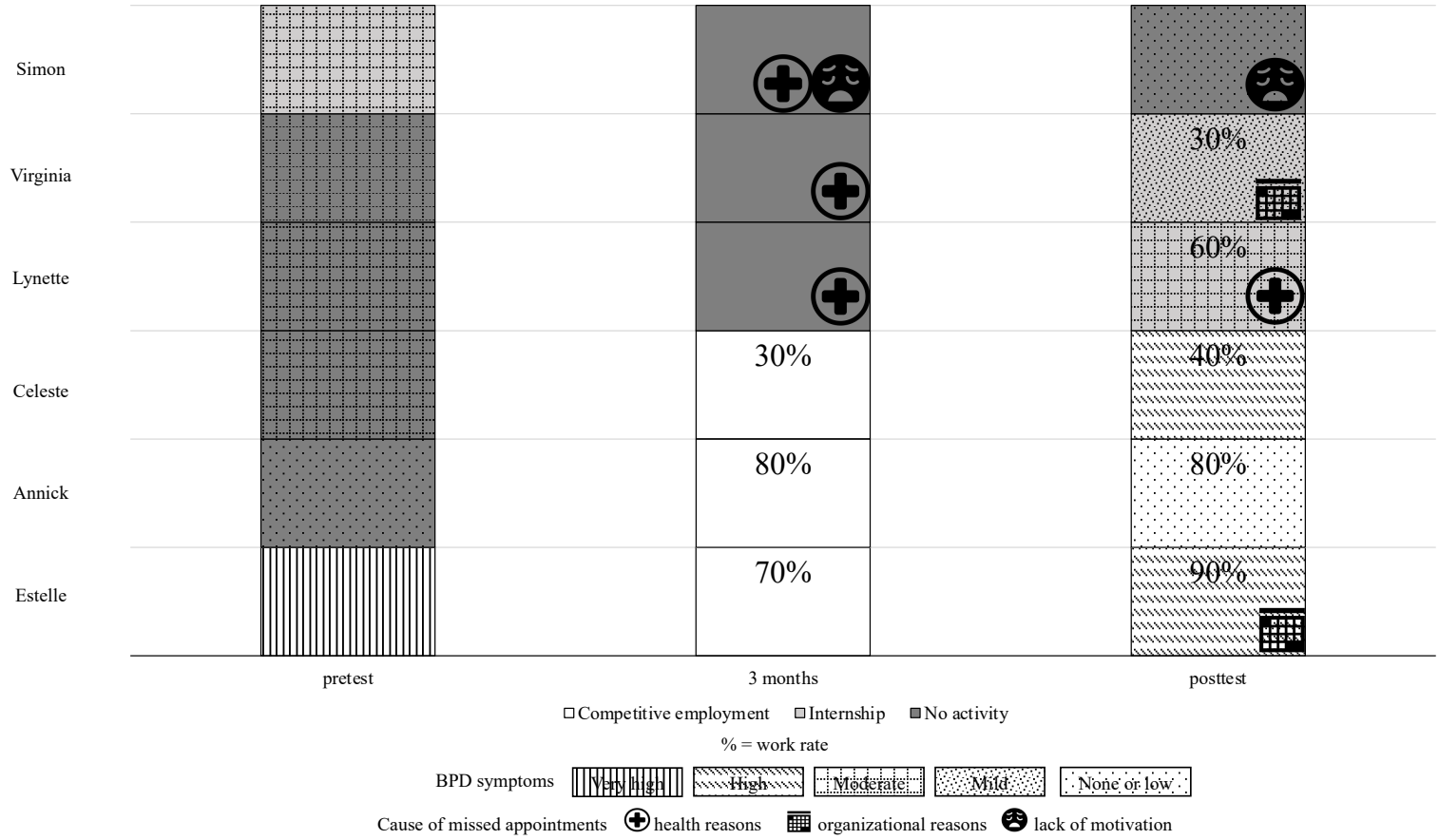
> [At] the first telephone interview [...], I didn't like her [the job coach], and I told her, well, I think they felt it, they both told me, they were in [the psychiatrist's] office and when they hooked up, I think they understood very well that I was upset and yet I was holding back. But without even knowing her, I didn't like her... (Celeste)

Part 3: Descriptive statistics

Figure 5.1 shows the evolution of the participants throughout the intervention. Estelle already had a job when she entered the study and managed to retain it and increase her work rate. Annick and Celeste found a job very fast after the beginning of the study: after respectively 2.5 and 3 months. Annick's work time was at 80% and Celeste's weekly work rate was increasing. Virginia and Lynette found internships at the end of the study. Simon's internship came to an end, and he did not find any activity during the 9 months of intervention.

Figure 5.1

Borderline Personality Disorder Clients' Evolution Throughout Individual Placement and Support Intervention with Good Psychiatric Management-Trained Job Coaches



Note. BPD = borderline personality disorder.

Annick's symptoms remained absent or low throughout the study. From the interviews, she seemed to have high degree of insight about her illness. Half the participants had lower BPD symptoms at post-test compared to pre-test. Lynette's symptoms remained steady at a moderate level. Celeste is the only whose symptoms level increased.

Diligence in the programme was rather good. During the first 3 months, the ones who missed appointments were those unemployed. They justified their absence on health grounds. Additionally, Simon sometimes missed appointments by lack of motivation. The last three months in the study, the same participants were

still missing appointments sometimes, as well as Estelle. But only Lynette missed because of health problems. Estelle and Virginia justified their absence on organisational grounds. Simon was still demotivated sometimes, which explains their lack of diligence in IPS. Simon was also the most dissatisfied with the programme according to the interview, and the only one who was not very satisfied according to the questionnaires. Overall, the satisfaction expressed in the interviews corroborated the scores on the STTS-R.

The only two participants who stopped IPS before the end of the study were Celeste, who had been cared for in IPS for 6 months, and Simon, who had already been enrolled for 15 months without finding competitive employment. Celeste had to leave the programme due to her advanced state of pregnancy: Her professional goals had to be postponed. As mentioned, Simon was demotivated and decided to turn towards Invalidity Insurance as they felt their work capacity was durably impaired. The clients' job coaches judged half of them ready to work at 3 months, and 100% of them at post-test.

5.5 Discussion

This is to the best of our knowledge the first study assessing the relevance of adding GPM training to IPS, using mixed data collected with people with BPD at different timepoints. All but one of the participants were women, although this is representative of persons living with BPD (Schulte Holthausen & Habel, 2018). The main attitude seemed positive. More features mentioned by the participants appeared to fit in the positive subthemes, than in the corresponding negative ones, except for satisfaction with the intervention. Additionally, none of the elements on

the negative side were shared by all participants, unlike in the positive one, where at least one code for each theme was mentioned by all of them.

Globally, many of the codes and subthemes were related to GPM in particular and not IPS in general. Despite the present study not being a controlled trial, many positive elements in relation with BPD symptomatology were evoked by the clients. This is also in line with what job coaches reported about the feasibility and appropriateness of using GPM in an IPS setting (Dunand, Golay, et al., 2024).

Generally, clients were very satisfied and would recommend the intervention. Their environment was stabilising: All but one had an activity at the end, most of them with an increasing work rate, and a steady or decreasing symptom level. This is better than what could be expected given the fact that only 55% or BPD clients have a fair work capacity 10 years post-treatment (Zanarini et al., 2009). The only participant whose symptoms level increased had started a job, a training and became pregnant during the study, which might explain the stressful time she was experiencing. The participants whose symptoms remained moderate had started an internship, which could also have been stressful. The participants whose symptoms remained low or absent was the oldest and had high knowledge about her illness. This is in line with the importance given to psychoeducation as a central feature of GPM. It might be explainable by the findings that certain BPD symptoms tend to decrease with age (Stevenson et al., 2003). Time to find employment was very short, as compared to previous Cluster B PD results at RESSORT–before GPM implementation (Dunand et al., 2023)–and other IPS studies (Burns et al., 2015). Job coaches rated all their clients ready to work at post-

test, compared to only half after 3 months. Also, an alliance was being built. These are all factors suggesting a successful use of GPM. Moreover, a strong alliance predicts success in supported employment (Corbière et al., 2017, 2023).

There was no sudden intervention attrition or missed appointments without any reason given, which are promising elements going in the sense of a certain level of satisfaction with the intervention, and of a strong alliance (de Freixo Ferreira et al., 2023; Steuwe et al., 2023), especially for this population who tend to irregularly complete treatments (Arntz et al., 2023; Barnicot et al., 2011; Iliakis et al., 2021). Reasons for cancelling appointments were organisational for two participants who had an activity, which might be the reason of this unforeseen event. The ones who missed appointments for other reasons (health and lack of motivation) did not have a competitive job. These two outcomes could be correlated in the sense that employment positively affects psychiatric service users well-being (Bejerholm & Eklund, 2007; Bond et al., 2001; Burns et al., 2009; Koletsi et al., 2009; Strickler et al., 2009; van Niekerk, 2009).

On the basis of Proctor et al. (2011)'s service implementation indicators, we can deduce that at least some seemed respected by the clients' job coaches: acceptability, appropriateness, and fidelity. Given participants' satisfaction and the positive alliance that were built throughout the programme, acceptability seemed present, although some participants portrayed an irregular commitment into the intervention, and occasional unease for communicating problems with their job coach. Regarding the first point of the threatened alliance with irregular commitment, empowerment and motivation, it might be at least partially attributed to the BPD's typical tendency to have unrealistic expectations towards others,

including their caregivers (American Psychiatric Association, 2015). Clients might rely on them, with idealised hopes of being taken care of without furnishing any effort. And lack of motivation has been found to be associated with poorer vocational outcomes in supported employment (Viering et al., 2015).

The implementation looked to some extent appropriate and suitable from the clients' point of view as they reported several aspects showing satisfaction with the intervention, stabilisation of their environment and the presence of contractual, working, and relational alliance. The appropriateness remains in part questionable because of the weak health-related evolution and the 50% rate of failure in finding a competitive job in the programme during the study–which is nonetheless lower than the usual average rate at RESSORT (Dunand et al., 2023) and in most IPS European studies (Bond, Drake, et al., 2012; Bond et al., 2019). Though, most clients were already quite stable, hence the progress margin in terms of symptoms was low, and professional situation success or improvement cannot only be measured in relation to work status. Most clients pointed out their motivation to integrate the job market, the importance of finding an occupation, which almost all of them did, and their strategies to avoid problems on the workplace. These are potential elements to support the appropriateness of the intervention. Additionally, clients' interviews took place after about 9 months of intervention since the training of their job coach, which is not a very large amount of time to observe drastic professional situation change given the IPS literature (Frederick & VanderWeele, 2019), especially for people with BPD who are part of Cluster B PD DSM categorisation, which frequently need more time to find their first job (Dunand et al., 2023). Also, the recurrent complaints interviewees had in regards of their

arduous professional reintegration inevitably raised the question of their perception of the world in relation to their diagnosis. Indeed, almost all of them mentioned illegitimate dissatisfaction of their line manager, requirements in terms of work conditions, and external factors hindering their vocational success. It is hard to know to what extent this vision is due to the disorder or what objectively is problematic in the situations they encountered, given the fact that these issues are all frequently associated with BPD, from difficulties to acknowledge one's own mistakes (Baer & Fasel, 2011) and conflicts at work (Hengartner et al., 2014) to idealised expectations (American Psychiatric Association, 2015) as mentioned earlier. Even so, it is important to mention that the RESSORT team's weak point on the IPS fidelity scale (Bond, Peterson, et al., 2012) is the frequency of contacts with employers for prospecting for jobs, which was therefore a legitimate regret of clients that could indeed have an impact on effectiveness of the programme. The perspective of implementing GPM in a higher fidelity IPS team can consequently be expected to be even more promising.

We can assume that the healthcare providers were faithful and adhered to the model given the clients' description of contractual, working, and relational alliance. However, half or less of the clients also mentioned the confusion around intervention time, irregularity in goals assessments, the absence of a joint crisis plan and a deficit in the care network collaboration. It is legitimate to wonder whether these deficits are due to lack of clarity from the coaches' side or to forgetting or deficit in understanding from the service users' side. The joint crisis plan was seen as an interesting tool by the job coaches–from our parallel study (Dunand, Golay, et al., 2024)–right after the training, but they apparently have not made it a

systematic practice. On the other hand, for the rest of the above-mentioned points, they all reflect job coaches' stated issues in our complementary study (Dunand, Golay, et al., 2024): confusion between the IPS principle of time-unlimited support and GPM framing intervention, remaining difficulty in setting goals with unstable service users, and the need for a functioning collaboration with the client's network, which depends not only on them but on mutual will.

Some level of difficulties is also unavoidable: Clients' health still depends more on psychotherapeutic work than on the job coaches who are not meant to be in first line or in charge of treatment. Furthermore, even though GPM is applicable and good enough for most service users, some of them will still need BPD specialised therapies to evolve positively (Gunderson & Links, 2014).

A potential bias of this study is that the clients who agreed to take part were potentially those who had a positive attitude towards the intervention and the relationship with their coach who made the connection with the research team. Some people with BPD enrolled in IPS were not offered to participate by their job coach, believing that the absence of an alliance did not allow them to broach this topic. Another limitation is that this study was led in Vaud, Switzerland; Current conclusions might not be transferable to all IPS centres. Finally, clients were only exposed to one version of IPS: the one practiced by GPM-trained staff. Further studies should include a control group to compare this form with the classic IPS intervention.

In order to assess long term effects of the implementation, it would be interesting to test the service and its users on several indicators at a later stage. The quantitative study of clients' outcomes is still underway, with the aim of analysing

whether the visible increase in ease of job coaches and clients' satisfaction really translates into greater success in terms of professional reintegration and non-vocational outcomes. The following step would be to compare IPS effectiveness with and without GPM-trained job coaches, and with other borderline-specific vocational programmes, such as DBT-SE (Feigenbaum, 2019) or BIWI (Larivière et al., 2022) in RCT, and if proved effective, to work on the implementation methodology to generalise the use of GPM in other teams.

5.6 Conclusion

This study shows the satisfaction, environment stabilisation and building of an alliance of people living with BPD following IPS with GPM-trained job coaches. According to clients' discourse, the IPS team seems to have accepted and be faithful to GPM principles. In that sense, GPM appears to be a good addition to the IPS job coaches training when facing a BPD population. Positive effects could increase with more fidelity to the IPS model, more clarity from job coaches in the help they provide, and more adapted BPD treatment for clients outside of IPS. The quantitative study, from which some results are presented in this paper, is still ongoing at RESSORT, in order to better identify the vocational and non-vocational effects of the IPS intervention carried out by GPM-trained healthcare providers.

9

[9] SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

6. General discussion

People living with PD present vocational impairments and are seen as a challenge by health caregivers. In this thesis, we first confirmed the presence of these difficulties in a local context of IPS. This secondly led us to set up a pilot study of integration of GPM into IPS. Quality implementation frameworks were followed for this purpose.

6.1 Evaluation of implementation stages

With respect to the 14 critical steps of the Quality Implementation Framework by Meyers et al. (2012), most of them were followed in this study. The extent to which they were applied appears in Table 6.1. All steps have been addressed, empirically or theoretically. Some have been deeper evaluated and documented than others. One of the main objects of the present thesis was the process evaluation, which is the 12th step. We based this assessment on the eight implementation indicators of Proctor et al. (2011). Thus, it can be suggested that GPM in the context of IPS is accepted (1), adopted (2), appropriate (3), and feasible (4). The team shows fidelity (5) to it in their practice. Clients are satisfied and experience symptomatic improvement. However, it is important to be conscious of the few points to improve, that are mentioned further in the study's summary. We also note the need to confirm these results.

Table 6.1

Steps of the Quality Implementation Framework of Meyers et al. (2012) Applied to the Present Thesis

Phases	Steps		Application of the steps in this research
Phase 1: Initial considerations regarding the host setting	1.	Needs and resources assessment	It was carried out in the first two studies of this thesis, which identified difficulties for clients with PD and those present in the team.
	2.	Fit assessment	It took place at the theoretical level, as justified in the section dealing with the overview of this thesis in its main introduction: GPM and IPS constitute two compatible and complementary logics for care.
	3.	Readiness for change	This was not empirically evaluated. It was assumed through the motivation of job coaches to find solutions to the highlighted difficulties, according to the study of their difficulties, and their team discussions.
	4.	Possibility for adaptation	It was also done at the theoretical level. To prepare for the training, the GPM manual by Gunderson and Links (2014) was reviewed. We selected the sections which are relevant to the context of supported employment. We illustrated the different chapters using examples that could resonate with the practice of IPS job coaches.
	5.	Buy-in from essential stakeholders	This was explicitly obtained, which helped fostering a supportive climate. Indeed, the cantonal coordinator of the RESSORT programme where the implementation took place was an important lever in setting up the GPM training. She had to justify obtaining funds for financing monthly supervisions by an external psychiatrist, whose visits she had to organise too. She also regularly encouraged job coaches to participate in the study and to invite their eligible clients to do so. IPS job coaches were not consulted in the implementation initiative. Nevertheless, some had expressed the need for training and were open to solutions to guide them in supporting people with BPD. Additionally, they were able to participate in training and supervision voluntarily. In that sense, we followed Wanderman and Florin's (2003) proposition that practitioners, researchers and funders are all mutually accountable and should collaborate in the aim of achieving best possible outcomes in implementing an innovation.
	6.	Building organisational capacity	This step was not applicable for this project. I had to acquire in-depth knowledge of IPS, GPM and the evaluation of an implementation, to integrate them into the team, but no profound adjustment was required.
	7.	Necessary staff recruitment and maintenance	The external psychiatrist was recruited to conduct long-term GPM supervisions. Job coaches were tasked with putting the newly assimilated elements into practice, participating in the research themselves, and proposing study participation to their clients.

			In my research mandate, I was identified as the person of reference for the implementation. I was thus tasked with training the team and evaluating the implementation of this new modality in IPS with the support of the cantonal coordinator. However, the question arises about the sustainability of the project. Indeed, the team is evolving, new members have joined since the training, which they have hence not received. They benefit from supervisions and have access to the material used for training, but both old and new team members acknowledge the need for regular training reminders, and current resources do not allow such a project to be carried out. This potentially jeopardises the future of the implementation in the medium to long term.
	8.	Pre-innovative staff training	This took place primarily based on the GPM manual by Gunderson and Links (2014), of which positive effects have been scientifically demonstrated (McMain et al., 2009, 2012).
Phase 2: Structural characteristics for implementation	9.	Creation of an implementation team	Several stakeholders were involved for this feature. I had the role of trainer and the responsibility for quality insurance, as well as the evaluation of changes. My thesis supervisor and the RESSORT cantonal coordinator were available to support me in these tasks. Members of the research team from the community psychiatry ward of Lausanne University Hospital played a supervisory role in conducting a rigorous implementation. Finally, a GPM-expert psychiatrist, specialised in the treatment of PD is leading the monthly group supervisions.
	10.	Development of an implementation plan	A protocol was written and scientifically validated. The project included the specific steps and deadlines of the planned implementation process. It explained the way the latter would be controlled. The Cantonal Research Ethics Committee of the Canton Vaud, Switzerland, approved the project for its rigor and scientific relevance.
Phase 3: Continuous implementation support strategies	11.	Supervision	Supervisions still take place monthly in groups at RESSORT. However, regular updates on the content of the training would be welcome.
	12.	Process evaluation	It occurred at various times: immediately after the training, then 9 months later with the coaches. On the client side, their progress in the programme was measured at the time of entry into the study and then trimonthly for 9 months.
	13.	Supporting feedback mechanism	This is still ongoing, with the publication and sharing of the study results with, among others, those involved in the implementation.
Phase 4: Improvement of future applications	14.	Learning from experience	It is the subject of this thesis discussion. This, along with the studies presented in chapters 4 and 5, highlights the aspects of the implementation process that could have been done more explicitly and better documented, and what could be added for a more effective and sustainable integration.

Note. PD = personality disorder; GPM = Good Psychiatric Management; IPS = Individual Placement and Support.

We can also address the implementation indicators mentioned by Proctor et al. (2011) that were not explicitly questioned within the study as our research focused on an individual level rather than on the institutional one. First, the costs (6) of such a project are low: It consists of a day of training and monthly supervision. The frequency and group format of the supervisions seem to suit the team. Increasing the frequency of training would inevitably have a cost, and the research associated with the study as well. It would therefore be necessary to estimate the expenses associated with training and supervisions: fees of the trainer, the expert who supervises the team and the time allocated by the job coaches for supervision sessions. Then, it would be useful to calculate the potential benefits for the institution if clients successfully reach their goals, resulting in reduced session frequency and intervention duration. Additionally, the final projected cost could be compared to that of other vocational programmes for people living with BPD.

Second, the penetration (7) of GPM into the team's culture was also not measured at the institutional level as such. It would be interesting to investigate this question. It can be calculated by dividing the total number of people in the team providing IPS service by the number of people in the team providing IPS service who are trained to GPM. Currently, at RESSORT, the equation would be as follows: 17/12=1.42. This score, close to 1, indicates a reasonable level of penetration of GPM within the team. Indeed, the coaches are satisfied and newcomers who have not yet been trained are interested in GPM. Some coaches printed and displayed GPM principles in their offices. The team discusses PD in the light of GPM and regularly attends supervisions. Therefore, successful penetration can be assumed.

Finally, sustainability (8) was not measured in the various studies constituting this thesis. It should be measured through three criteria: permanent financing, integration into routine practice of service providers, and into the organisation. At RESSORT, supervisions are still ongoing and planned for the current year. New job coaches who joined RESSORT after the beginning of the study have been informed about the focus of the team on BPD. They have access to related documentation and participate in GPM-specialised supervisions, although they would also need a formal training session. Also, the institution's research projects continue in the direction of better care for people with PD within IPS. Consequently, it seems that the implementation is sustainable, even if resources would be needed to regularly provide training to the team.

Level of implementation success is a function of both treatment and implementation outcomes (Proctor et al., 2011). Our moderate evidence of GPM and IPS integration effectiveness requires additional data. However, the implementation outcomes show positive results, in terms of acceptability, adoption, appropriateness, feasibility, fidelity, cost, penetration and sustainability. We can therefore argue that the implementation success is moderate to high.

6.2 Individual Placement and Support for people with personality disorders: Effectiveness and job coaches' experience

Regarding Meyers et al's (2012) phase 1, we assessed initial considerations concerning the host setting through two studies. We first sought to investigate variations in vocational outcomes in IPS programme among individuals categorised

into four groups: PD Clusters A, B, and C, as well as other mental disorders. PD of Clusters A and especially B negatively impacted IPS success in vocational rehabilitation. They less frequently obtained employment during the IPS intervention compared to others. This constituted an evidence of needs for strategical change, as required in Meyers et al.'s (2012) first step towards implementation.

Individuals in Cluster C seemed to succeed as well as those without PD in the IPS programme. Those in Cluster B were the most disadvantaged, more often finishing the IPS care without any activity and less frequently with employment in the competitive work market than others. Moreover, when they accessed a job, it took them more time than for others, with an average of over 12 months in the IPS programme. The study by Burns et al. (2015) showed that beyond 9 months of participation in IPS, the chances of obtaining employment drop drastically. Burns et al's (2015) results corroborate those of our study for all disorders, except for individuals with PD in Cluster B. The latter appeared to require a longer intervention time before being able to access vocational reintegration. This is not surprising given that Cluster B includes BPD, which is associated with numerous vocational dysfunctions widely referenced in the literature (Bagge et al., 2004; Black et al., 2004; Jovev & Jackson, 2006; Sio et al., 2011; Skodol et al., 2002; Zimmerman, Chelminsky, et al., 2012). The present results also follow the trend observed by Hengartner et al. (2014), with individuals with PD of Clusters A and B showing more severe professional functioning impairments than PD of Cluster C.

We then aimed at examining the challenges and facilitators encountered by IPS job coaches facing people with PD in contrast with individuals with SMI. Consistent with the lower effectiveness of IPS for people with PD, IPS providers also reported a greater number of difficulties in the care of people with PD than for others. Unlike difficulties related to other disorders, those encountered with people with PD were mainly relational, in line with what is known in the literature for this type of pathology (Ettner et al., 2011; Hengartner et al., 2014; Sansone & Wiederman, 2013; Sio et al., 2011). These obstacles were thus felt at the level of the relational alliance, which was thereby altered.

However, IPS job coaches have brought forth several ideas to overcome the identified issues. They suggested better framing interventions, promoting team cooperation and collaboration with clients' healthcare network, sharing responsibilities with their clients, and relying on scientific research. They also raised the employers' awareness about mental illness as a facilitator in professional reintegration for all their clients. However, they reported that disclosing a mental disorder was more difficult in the case of a PD than a SMI. They described that this was because people with SMI possessed a better understanding of their illness, hence were more likely to manage their health, which could be an argument towards employers. They explained that the manifestations of cognitive disorders in people with SMI are less frightening to employers than manifestations characterising PD, such as temperament symptoms. Companies were therefore more likely to hire someone with SMI symptoms than PD symptoms. Efforts on deconstructing stigma among the work market is needed.

Additionally, job coaches offered solutions that are, in fact, part of the guidelines of GPM for BPD, which lists the recommended attitudes for mental health professionals in the care of these service users. IPS coaches notably encouraged more regularly evaluating the benefits and achievements of PD clients' goals in IPS. They suggested to frequently question the added value of this intervention for each specific case, potentially limit the duration of the care, and collaborate with experts in this type of disorders. This showed fit for GPM implementation, which is necessary according to the Quality Implementation Framework (Meyers et al., 2012). Moreover, the coaches highlighted their motivation to receive more ongoing training, especially for treating individuals with PD. This demonstrated the team's needs, resources and readiness for change, necessary for the implementation according to Meyers et al. (2012).

6.3 Good Psychiatric Management implementation in the context of Individual Placement and Support

Thus, the implementation of GPM into IPS was a solution to the needs mentioned by the RESSORT IPS team. This led to a study aiming at assessing the initial integration of GPM for BPD into IPS practice. We conducted a pilot project using mixed methods. Job coaches were trained and attended monthly group supervisions, which are essential steps within the Quality Implementation Framework (Meyers et al., 2012). The consideration and communication of the following parameters are capital part of the evaluation of and feedback on such an implementation (Meyers et al., 2012). The coaches' experience was mostly positive. They adopted GPM principles, felt more comfortable and skilled, and perceived benefits for clients. They suggested systematising such training in all

psychiatric domains. Another indicator of their uptake on this new feature is that all 12 (at this time) IPS job coaches participated in the training. Nine of them further engaged in either the subsequent focus group, individual interviews, or both. The three remaining job coaches also contributed to the study by referring some of their clients to participate in the research for the part concerning service users.

Nevertheless, job coaches reported that some factors prevented them to do their job well. For example, some clients refused that their job coach would contact their former or current employer, while such an exchange would be of great help for job coaches to understand their client's complete situation. However, clients' distrust in this regard is understandable. Some of them described understanding employers who were eager to set up adjustments on the workplace, while others told that they were fired after disclosing that they had a BPD. Anyhow, contacting employers remains RESSORT's weak point on IPS fidelity scale (Bond, Peterson, et al., 2012), because of the difficulty to access employers who often lack knowledge about mental illness. Destigmatising mental illness in the employment world remains a challenge.

Apart from this, the difficulties presented by the coaches following the training are more related to a lack of practice with certain elements of GPM than to an impossibility or refusal to do so. This is promising and suggests potential developments over time. Job coaches are aware of a certain margin of improvement still present in their practice. The points that may seem more problematic at first are the impression of incompatibility between IPS principles based on service user choice and those of GPM, which are more structuring. Clients also note some

misunderstandings, notably regarding intervention time for example. This lack of clarity seems to be directly related to the confusion that job coaches may feel in the face of the apparent contradictions between IPS and GPM fundamentals.

This constitutes an area for improvement in the training, which should emphasise how to stay attuned to clients while providing a clear framework. GPM also encourages service user empowerment in their care. The key would be for example to give clients the choice of their professional project, build it in depth in partnership, and make them understand that to reach such goal, they need to commit to certain constraints. A future training should further highlight that the psychoeducation advocated by GPM can also be informal, which IPS coaches are more likely to practice. They can draw on events experienced by clients within or outside the intervention, which may impact their vocational rehabilitation. Formal psychoeducation about BPD should be left in the hands of the client's frontline therapists. Additional advice could be in terms of collaboration with the healthcare network, notably for systematising the diagnostic evaluation of individuals suspected of having BPD. These elements are not specific to GPM; They are also present in the basic practice of IPS job coaches. Coaches would also appreciate regular training, perhaps on an annual basis. In this way, each new employee could benefit, and the more experienced ones would be reminded of the theoretical aspects of GPM. This would ensure a degree of quality control. It obviously requires human and financial resources. On a logistical level, healthcare professionals regret that the training took place online. This was due to the COVID-19 pandemic, but it should be noted in the future that face-to-face training could have a greater impact.

As for service users, most were very satisfied with their care and would recommend it. No sudden dropouts from the study occurred. Some clients reported irregular engagement in the intervention and difficulty in communicating honestly with their job coach. However, their discourse generally reflected the success of an intervention using GPM. The quantitative measures also supported this trend. Almost all clients showed positive changes over the course of the study, both in terms of their professional situation and symptoms. This is what is expected by the GPM theory, which states that occupational activities should be present for every person living with BPD by 6 months of treatment (Gunderson & Links, 2014). Half of the participants had obtained a competitive employment, which is promising considering the usual rates among treated BPD clients and in IPS research (Frederick & VanderWeele, 2019; Zanarini et al., 2009). However, these encouraging results are preliminary and need to be verified.

For the quantitative part, we faced the complexity of recruiting participants with BPD who were enrolled in the IPS programme. First and foremost, we encountered the known reluctance of therapists of some service users to label the presence of BPD. Coaches had difficulties in addressing this issue with these psychiatrists, who were probably hesitant to disclose such a diagnosis (Gunderson & Links, 2014; Tyrer et al., 2010). Without an official diagnosis, it was not possible to broach the subject with clients for whom BPD was suspected or recognised by the team. This brings us back to the idea of reinforcing collaboration between job coaches and the psychiatrists responsible for treating service users. The difficulties related to recruitment are also partly explained by the limited number of eligible

individuals: Few people diagnosed with BPD join the IPS programme at RESSORT each year.

It is important to note that this research had a direct positive impact on the attitudes of the various stakeholders involved. Those with BPD who agreed to participate in the multiple case study presented in this thesis expressed excitement for taking part in the research. The idea that research was focusing on their disorder, their medico-social support, and their interests, and that researchers were passionate about working on their health condition, filled them with enthusiasm. Participating in the study was not directly meant to help them, as their treatment would have been the same if they had refused to provide access to their data. Nevertheless, many were delighted to contribute to help others in the future, facing similar challenges. Some expressed relief in knowing that professionals were addressing their difficulties and that they considered the importance of their opinions and experiences. Clients were pleased to feel their scientific usefulness and that they were not alone in presenting this profile with the functional limitations it entails. Several even expressed motivation to establish a support group within RESSORT to share their positive and negative experiences of the disorder and its impact on their professional situation. This could be a potential avenue for exploration in the future. On their part, IPS coaches had previously mentioned their difficulties and the need for research on PD in the context of supported employment, leading to the implementation of GPM. After the integration, they also expressed satisfaction in the fact that their practices were being studied, their opinions valued, and efforts made to find solutions to the challenges they faced.

6.4 Possible implications of research

This promising implementation have numerous clinical repercussions. The two main goals of this research were to improve job coaches' clinical practice, and to ease the professional reintegration of individuals with a PD. Regarding the primary goal, IPS coaches mentioned their work to be smoother. The GPM addition provides comfort to healthcare professionals, as they said, and educates them about the disorder, fostering a more positive and supportive relational climate and reducing stereotypes. This favours more hope and confidence in one's own abilities and those of the clients to meet their needs.

This process should lead to the achievement of the second objective. According to our preliminary results, the professional integration of individuals with a PD is facilitated and more frequent. The new attitude adopted by the coaches seems more suited to the functioning and expectations of individuals with a PD. Thus, the care is improved, with clients feeling heard and understood, which refers to the relational alliance. They are therefore more motivated, satisfied, and engaged in their efforts towards professional reintegration, which refers to the concepts of contractual and working alliances. These parameters are important predictors of profitable care (Gunderson & Links, 2014) and success in the supported employment mission (Corbière et al., 2017, 2023). The discourse of IPS clients suggest that their environment stabilises as a result, notably reflected in better management of their disorder. This then provides a favourable ground for the professional reintegration of these individuals whose symptoms greatly affect the employment domain (Bagge et al., 2004; Black et al., 2004; Jovev & Jackson, 2006; Sio et al., 2011; Skodol et al., 2002; Zimmerman, Chelminsky, et al., 2012). This is

what the preliminary results of our implementation study suggest. Clients satisfied with their care and acknowledging a strong alliance with their coach saw their symptoms decrease and achieved their goal of professional reintegration. This investment is cost-effective and seems highly valuable. In that sense, job coaches supported the idea of providing GPM training on a larger scale, in other teams practicing IPS, or even in other psychiatric teams more generally.

Additionally, this thesis opens perspectives for reflection on the effects of introducing GPM into IPS on the issue of mental health stigma in the healthcare and workplace environments. Focusing on the challenges of individuals with a PD has enabled the RESSORT team to update their knowledge in this area, leading to a destigmatisation process among IPS coaches. This action supposedly may have also extended to clients affected by such disorders who benefited from the assistance of non-stigmatising job coaches, potentially reducing their self-stigmatisation through a snowball effect (Favre & Richard-Lepouriel, 2022; Ociskova et al., 2023). Overcoming stigma also contributes to the success of clients in IPS (Alverson et al., 1995).

Furthermore, GPM encourages greater collaboration with clients' care network. Job coaches require clear BPD diagnoses to practice GPM and for client inclusion in the study. Thus, this research has facilitated information sharing between IPS job coaches and frontline psychotherapists who treat the service users. This opened up dialogue and, once again, potentially contributed to breaking down certain stigmas associated with BPD. Publications and communications on the subject at conferences or within research teams also serve to raise awareness and

provide psychoeducation to readers and listeners. It contributes to updating their knowledge about the current needs regarding the recovery of people with PD.

The increase in comprehension of people living with BPD about their illness and its management induced by GPM should also help job coaches disclose the clients' limitations to reluctant employers. This was stated as a professional reintegration facilitator in the study about job coaches experience with PD versus SMI clients. If the integration of GPM into IPS helps people with PD accessing and retaining their job position, employers and co-workers would face people with mental illness who function well. The intervention could then, by extension, reduce stigma on the workplace.

6.5 Strengths of research

This research is one of the first addressing IPS for individuals with a PD. Only one other recent study has been conducted by Juurlink et al. (2020, 2022) in the Netherlands. However, they attributed the non-significance of their results to the heterogeneity of PD. Therefore, our research, which investigated the effectiveness of IPS for PD based on different clusters, represents a significant innovation. Moreover, this focus precisely addresses the current challenges of the IPS community, which aims to extend its research to more diverse populations, as a large majority of studies in recent decades has focused solely on SMI (Bond et al., 2019). It is now time to assess the effectiveness of the programme with other clients, considering that a central principle of the model is that of zero exclusion.

This study is also the first to test the integration of GPM into the context of supported employment. This approach emerges as a promising, cost-effective, and

evidence-based solution. It facilitates an enhancement of practices and improves professional, as well as symptomatic outcomes for clients. This occurs without deviating from the core IPS model, which is strict on quality and adherence to its principles in its worldwide teams.

Another strength of the current research is its use of mixed-methods scientific approach. Quantitative and objective evaluation of the outcomes of the support provided at RESSORT, coupled with the study of experiential discourses were complementary. Such methods have allowed for rich conclusions and insights into the question of supported employment for individuals with PD. Furthermore, in this context, voices were heard from both caregivers and users of the IPS service. In this way, we have gained a more comprehensive and integrative understanding of the different perspectives and stakeholders involved in a supported employment intervention.

6.6 Limitations of research

This research has some limitations concerning its external validity. Firstly, the fidelity of the RESSORT team to the IPS model is not optimal. In fact, the last fidelity visit to the team, dating back to April 2023, revealed a fair fidelity to IPS. The fidelity scale rates IPS centres as having exemplary high, high, or fair fidelity, or as non-compliant with the model (Bond, Peterson, et al., 2012). RESSORT is thus in the lowest stage of conformity to the model. This detachment from IPS principles is partially a choice, given the high demand for care in the region, which forced the team to introduce exclusion criteria. This could have influenced our results. Indeed, the second chapter of the thesis on the assessment of needs in the

practice of IPS for people with PD could receive more optimistic conclusions in a team more faithful to the model as it was conceptualised. The strict application of IPS principles is indeed a significant predictor of the success of supported employment (Becker et al., 2006; Bond et al., 2011; Corbière & Lanctôt, 2011; Viering et al., 2015). The low fidelity in the team where the data for this research were collected could explain the mixed results after implementation of GPM. For example, clients regretted the lack of connection between coaches and the job market, which is a key element of the IPS model. Nevertheless, the already promising results of this implementation could potentially increase even more in a different team. Also, in any case, this study has increased the skills of the team members, which is another major predictor of programme success (Corbière & Lanctôt, 2011; Corbière et al., 2023).

Moreover, the fact that some service users did not have an official BPD diagnosis not only resulted in a low number of eligible participants for the quantitative study of implementation, but also raises other issues regarding the treatment of the individuals involved in the study. It suggests a selection bias in our sample, potentially including only clients benefiting from better psychotherapeutic care. In addition, there was a lack of systematisation in the protocol for proposing the study to each eligible client. This resulted in a deficit of collaboration, albeit unintentional, between the clinical and research teams. Several members expressed waiting for the "right" moment or for a sufficiently secure relational alliance to be established before mentioning the existence of the study to their clients. Some even refrained from proposing participation to certain clients they deemed too fragile in terms of health, for example. This not only contributed to the difficulty of obtaining

a suitable number of participants but also created a bias in their representativeness, potentially including the most stable, cooperative, and involved clients. This is an interesting aspect to consider in future studies to explore how to best support coaches in their recruitment efforts. One option would be to better standardise the recruitment process in agreement with the RESSORT cantonal coordinator so that the study would be systematically proposed to every eligible client. In this regard, providing coaches with training on the basics and goals of clinical research could help demystify this field and motivate them to fully engage. Finally, another explanation for recruitment barriers was the mistrust shown by some clients to whom the study was proposed. A lack of trust is indeed characteristic of the disorder (American Psychiatric Association, 2015).

Furthermore, the recruitment difficulties outlined could have also affected the internal validity of the study. Indeed, these obstacles led us to modify the initial recruitment plan, which was to engage clients at their entry into the IPS programme. The inclusion criteria were then expanded. Service users could join the study at any point in their care, meaning that some clients had already been enrolled in IPS for several months, sometimes because their job coach had been late in proposing their participation. A few started IPS even before their coach was trained in GPM. Whereas other clients were included as soon as they entered IPS. This lack of standardisation makes the analysis of data from these individuals problematic, as the group is highly heterogeneous. Individuals were not at the same stage of care at the times of the pre-test, 3-month, and post-test measurements. For example, the employment situation of a person treated for more than 9 months at the pre-test provides information that is difficult to compare in terms of the quality of care with

that of a person enrolled in IPS for only one week. Moreover, the limited quantitative results to date in our multiple case study unfortunately did not allow us to fully deploy a mixed-methods approach in the implementation study.

Besides, the fact of being the only person whose main activity was devoted to this study constitute another limitation of internal validity. I had to assume roles that might have placed me in a certain conflict of interest. Due to a lack of collaboration between services, I personally trained the IPS coaches on GPM. I also conducted interviews with them, while they are my direct co-workers, and are not entirely unaware of my research questions. Additionally, I am the one who conducted the data and results analyses. Thus, a response bias could have been generated for participants who might want to please their colleague by confirming her hypotheses and praising the benefits of the training she had provided. However, since the coaches highlighted negative or neutral aspects, we can hope that the climate of trust allowed honesty in most of their discourses, and that this bias did not significantly impact the study's results. The same applies to the analysis of the results, which could have been biased by my own convictions.

Finally, the number of participants in each of the qualitative studies was relatively low, which in qualitative research can pose a problem of internal validity (Onwuegbuzie & Collins, 2007). However, the researchers were confronted with a repetition of information between participants in the final interviews, in which no new themes or sub-themes were conceptualised. It was therefore assumed that data redundancy had been achieved. Additionally, various methodological approaches were used. Different IPS stakeholders participated and completed each other’s point

of view: users and service providers. We therefore believe that this enabled us to gain a comprehensive understanding of the object of this research. In addition, aware of the last two potential pitfalls, I tried to adopt an objective stance and involved other members of the research team, from different backgrounds and at various stages of the process, to counterbalance the possible risks of bias.

6.7 Future directions

The study limitations appear nuanced and provide stimulating perspectives for future research on PD in the context of supported employment. The first is to conduct more studies on the effectiveness of IPS for PD. The RESSORT team reported noticeable difficulties in the professional outcomes of clients. However, nothing allows us to conclude on the presence of such challenges beyond this centre. This does not diminish the relevance of improving practices within this team. Although, the question of the need to extend a modification of IPS practices for PD remains open. In this regard, a very first RCT on the effectiveness of IPS for young people with BPD is currently underway in Australia (Chanen et al., 2020). This reflects a need and a growing interest in the issues addressed in this thesis. Furthermore, practicing the GPM with individuals with BPD cannot be deleterious, neither for the caregivers nor for the service users. It supports a harmonious intervention. Therefore, such training could be provided even if the vocational rehabilitation outcomes for this population prove satisfactory in other IPS teams. IPS effectiveness for BPD should also be put into perspective by comparing it with other professional reintegration programmes designed for this condition. Indeed, since the beginning of this work, several new options have

emerged and should be considered, such as DBT-SE (Feigenbaum, 2019) or BIWI (Larivière et al., 2022).

The participants' satisfaction with our study and the positive results on GPM (Keuroghlian et al., 2016; Masland et al., 2018; McMain et al., 2009, 2012) suggest that it would be beneficial for caregivers, service users with BPD, and public health costs to spread this training in different psychiatric contexts. Recent studies even propose extending GPM to PD other than borderline, such as narcissistic and obsessive-compulsive PD (Blay et al., 2023; Finch et al., 2021). This perspective aligns with the modern view and the dimensional model of PD (American Psychiatric Association, 2015; Hopwood et al., 2018; Skodol, 2014; Skodol et al., 2014, 2015; Tyrer et al., 2015; Widiger & Mullins-Sweatt, 2010). Following this vision, DSM-5 has developed an alternative model of PD that is both categorical and dimensional. This model consists in examining a broad factor, referred to as the level of personality functioning, in terms of both self and interpersonal aspects. The connection between this factor and various personality traits such as negative affectivity, antagonism/dissociality, detachment, disinhibition, anankastia, and psychoticism, is assessed. DSM-5 proposes to keep six of the 10 PD diagnoses from the previous version, built around these dimensions (American Psychiatric Association, 2015). In this view, different PD share similar symptoms–hence the comorbidities. However, the triggers to hypersensitivity, described in GPM, would change according to the personality traits. In that sense, the model of interpersonal hypersensitivity developed in regards of BPD, could variate with other triggers than perceived interpersonal stress. Obsessive-compulsive PD is therefore triggered by threat to control and narcissistic PD by feeling of threatened self-esteem (Blay et

al., 2023; Finch et al., 2021). These models have not yet been strongly empirically tested but the case studies are encouraging. Concerned service users appear to adopt this conceptualisation of their disorder. Therewith, cases of narcissistic PD are regularly brought up during GPM supervisions at RESSORT, and the psychiatrist follows the usual BPD guidelines to shed light on the situation at play.

We could imagine going further and adapting this model to all PD categories that remain in the alternative dimensional model of DSM-5 (American Psychiatric Association, 2015). What triggers hypersensitivity and symptoms in the case of antisocial PD could be stressful events, inducing aggressive behaviours, for example. Avoidant PD symptoms would be triggered by social situations, resulting in fear for negative evaluation or embarrassment. Schizotypal PD could be induced by interpretation of thoughts, feelings, or intentions of others. GPM shows signs of good application to various PD, in the way that it helps service users apprehending their world in a different manner. The characteristics are the same. The focus remains on getting a life through working on corrective experiences. The only obvious required adaptation is in the content of the new comprehension models, notably for psychoeducation purposes. For example, the understanding of how symptoms activate would vary across different types of PD. This would imply more training, notably in a context such as the one of IPS, where healthcare providers do not possess extensive knowledge about psychiatric disorders. Future research aiming at expanding GPM to other populations is welcome, as this could be an easily implementable solution that could benefit a larger number of people.

All RESSORT IPS coaches interviewed in our implementation study also highlighted that GPM helped them in supporting individuals with disorders beyond BPD, and even beyond PD. They mentioned several GPM guidelines as applicable to all their clients. For example, the importance of a clear structure within the intervention was particularly useful for reassuring people with avoidant PD or anxiety disorders. Preventing over-interpretation of clients with psychotic or bipolar disorders was mentioned. Overall, job coaches believed that any client in crisis would appreciate a clear framework. They also emphasised psychoeducation, caring for the relationship, and fostering accountability as important in all disorders, acknowledging that it was even more essential for people with BPD. Additionally, they noted the relevance of some principles as commonly beneficial for all their clients. This was the case of conveying that change is expected, focusing on life outside treatment, and the use of good sense, particularly regarding the regular assessment of relevance of continuing the IPS intervention for a client. Generally, the fit of all these principles with a large category of individuals was explained by a job coach by the fact that different disorders share common symptoms. They also said that most clients could, at some point, experience BPD-typical difficulties, such as relational problems or unrealistic expectations. Also, the issue regarding disorders that have not yet been diagnosed represents a challenge in offering psychoeducation, beyond the case of BPD. The extension of GPM to disorders other than BPD constitutes an interesting track.

However, health caregivers need to use common sense. Indeed, as one job coach pointed out, people with BPD require an extremely strict framework, notably regarding compliance. In contrast, the intervention could go more in the direction

of the requests of people with SMI, as in the way the IPS model was designed. For example, clients and job coaches should agree early in the intervention to commit to appointments. In the case of PD, they should, for their good, be dismissed from the programme if they do not respect their commitment. Whereas people with SMI should benefit for more margin when they display a lack of adherence to the intervention, as this could be explained by forgetfulness due to their cognitive deficits, for example.

Furthermore, expanding GPM to other disorders than BPD would be a solution to overcome difficulties in recruiting a large enough sample for clinical studies on the topic. As a researcher at RESSORT, I would go in this direction in the case of a new research protocol. We could relaunch a pilot project to confirm the effectiveness of GPM in IPS for individuals with BPD. This would be a continuation of the study presented in this thesis. We would implement various improvements following this research. In regards of the recent findings, people with PD with any personality trait would be eligible. In that sense, the five dimensions of personality traits could be assessed to be linked with the main outcomes. These would remain the same as in the present research: activity type, work rate, time before first employment, diligence in the programme, work readiness, symptomatology, and satisfaction with the intervention. Literature is missing to try and include clients with disorders other than PD as well. We would follow participants for a year, from the moment they enter the IPS programme. This timeframe seems reasonable to observe change. Indeed, a job should be found within the first 9 months by most employable participants in IPS (Burns et al., 2015). Also, occupational change is expected by 6 months with GPM care

(Gunderson & Links, 2014). Additionally, more than half of people with PD had found a competitive job within the first year enrolled in IPS in our study of IPS without GPM (Dunand et al., 2023). Comparing the amount of time needed in this study to time once GPM has been implemented would be informative. Considering IPS clients flow at RESSORT (Dunand et al., 2023), we could expect recruiting around 30 service users over a year. In total, the study would then last for 2 years.

To successfully carry out this project, it would be necessary to provide GPM training for IPS to all coaches at RESSORT. Regular training reminders have been requested, and some employees have been renewed. As mentioned, some adaptation to the previous protocol would be required. To start with, we would have to review the training to fit to all cases of PD. The need for a closer collaboration with healthcare professionals and employers should be highlighted. Involving clients' care network would be a solution to avoid the issue of undiagnosed disorders and the difficulty in communicating about it. In a broader perspective, the care of individuals with PD by specialists in the field would be a real asset to their recovery. With regard to collaborating with the job market, we should provide job coaches with concrete tools on how to proceed. For example, a guide on the way to approach employers about people with PD on their limitation, could be established. As mentioned in our qualitative study of IPS job coaches' experienced difficulties and facilitators, we suggested using extreme personality traits in their softer version to transform them into strengths that counterbalance impairments. Additionally, Proctor et al's (2011) indicators for implementation that were not specifically addressed in the presented studies, could be explicitly assessed. Costs, penetration of the innovation into the organisation, as well as sustainability of such integration

could then be measured. Finally, job coaches could be trained to the basics of clinical research purposes, to show them the legitimacy of participating in such studies. A clear recruitment protocol should be written. This would be used by the research team with the support of RESSORT cantonal coordinator in the weekly team meetings to remind job coaches to systematically offer each new eligible IPS participant to enrol in our study.

If the results continue in the same direction and are conclusive, it would be possible to envision a larger-scale study. Given the relative scarcity of eligible clients and the specific context of RESSORT (Vaud, Switzerland), we could consider a multicentre study, involving, for example, supported employment teams of Switzerland in Geneva, Bern, and Zurich. Thus, a RCT could be conducted, comparing the IPS support for individuals cared for by a trained coach with that of an untrained coach in GPM. In this regard, a multicentre study would be more suitable, especially since most IPS coaches at RESSORT are already trained and aware of our research questions related to PD. Such collaboration could also bring positive elements to the quality of supported employment services by standardising practices across Switzerland at a national level, as it is the case in many countries. This would likely have the parallel effect of increasing national fidelity to IPS.

6.8 Conclusion

IPS supported employment appears to be less suitable for individuals with a PD. This is visible in their employment outcomes and in the discomfort experienced by job coaches. However, further extensive studies are still necessary on IPS and PD. GPM seems to be an interesting addition to facilitate the practice

of IPS with individuals with BPD. The tool is accepted by both coaches and users. It is easily implementable in different contexts and useful for various professions in psychiatry. The integration has taken place in the RESSORT team in a sustainable manner: Clinical supervision continues, and the implementation is still ongoing.

These preliminary results provide promising perspectives for further studying the impact of GPM in the context of IPS. Its implementation for other PD than BPD also seems to be a possible avenue. In this respect, one way could be to conduct such pilot study with people with PD of any kind, incorporating adjustments in view of our results. The training provided in the current research should be improved by emphasising the compatibility between GPM and IPS. The implementation process can be made more fruitful by systematising the practices of service user inclusion in the study, with even closer collaboration between clinical and research teams. On a later stage, if relevant, a multicentric RCT of GPM integration into IPS could be considered.

This would at the same time give more support to GPM. GPM is based on the American Psychiatric Association's (2001) guidelines, themselves founded on review of empirically validated treatments of BPD. This gives validity to the approach. Nevertheless, this specific combination of best practices has not yet been extensively studied. Only one RCT (McMain et al., 2009, 2012) has been conducted to show GPM effectiveness as a treatment for people with BPD. More evidence going in this direction is still needed. RCT are the highest type of studies in the evidence hierarchy in terms of unfiltered information (Desai et al., 2019).

Unfiltered research refers to studies for which data are collected and interpreted directly. RCT demonstrate good evidence for a treatment. However, these studies quality and results need to be filtered out through systematic reviews or meta-analyses, which gathers best available evidence, to reach the top level of excellence of the evidence pyramid (Desai et al., 2019; Wallace et al., 2022). In that sense, more studies on GPM need to be conducted.

Besides, the present work could benefit the country financially. The professional integration of a greater number of individuals also implies a reduction in public expenses. Being inactive has a cost for the state and its citizens. People without employment often have access to financial assistance such as reintegration income for those lacking sufficient funds to meet their basic needs. The Swiss Regional Employment Centres provide monetary support for those entitled to unemployment benefits. The Swiss Invalidity Insurance can provide pensions or contribute to professional income through daily allowances. These are intended for citizens whose diagnosis is recognised as partially impairing their ability to work. All the indirect costs of mental health issues, including unemployed individuals and those with reduced work productivity, represent on average 1.6% of the gross domestic product of European countries and more than 40% of the total cost of mental illnesses in Switzerland (OECD/EU, 2018). The total government expenditures on the mental health of individuals with a PD are 16 times higher than for the general population (Hastrup et al., 2019). Thus, potential political benefits could be perceived in the case of a successful implementation on a larger national or international scale, considering the respective functioning of social protection systems beyond the Swiss borders.

Therefore, a broader parallel project for destigmatising mental disorders among the entire population, including healthcare providers and employers, should be led at a political level. A real collaborative effort between the workforce, healthcare providers, job coaches, and service users could then emerge. This work has contributed to destigmatising healthcare providers through the implementation of GPM.

Such efforts should not stop there. As highlighted in our various qualitative studies with job coaches, employers still appear reluctant to hire individuals with mental health disorders. This is notably due to a lack of knowledge, which is often a source of distrust (Corrigan et al., 2008; Kosyluk et al., 2014; Østerud, 2023). If the professional stability of individuals with PD improves through the introduction of GPM into IPS, such a project would simultaneously contribute to destigmatisation in the job market. Employers would likely be less reluctant to hire individuals with mental health disorders if their involvement does not lead to deterioration of the work environment.

In that sense, the potential future project that we expounded to further study the use of GPM in IPS context for people with PD, could benefit from hiring peer practitioners living with a PD in the research team. Such practice is promoted in Anglo-Saxon countries (Faulkner, 2012; Faulkner & Thomas, 2002; Rose, 2014) and is recommended by the Swiss Federal Office of Public Health (Vincent & Staines, 2019). This way, service users could put their knowledge at the service of such research design to enrich it. They would at the same time be employed, which is the main concern of this work, and this would lower stigma and preconception

that can still exist in teams in psychiatry. The Community Psychiatry Wards of Lausanne University Hospital, where RESSORT is implanted, already includes peer practitioners in their research (Bachelard et al., 2023). This seems beneficial to collectively produce knowledge by the diverse stakeholders represented in clinical research.

The logic of IPS and its principle of systematically developing links with the job market is also a way to promote and raise awareness about mental health in companies. A study on the implementation of IPS was conducted in four European countries: France, Italy, Norway, and the Netherlands (L. de Winter, personal communication, October 20, 2023). It showed that of the 25 items on the model's fidelity scale (Bond, Peterson, et al., 2012), the one related to the development of links with businesses, involving frequent contact with employers, received the lowest score. This aspect represents a weakness in Europe. This is also found in the RESSORT team, according to its latest fidelity visit in April 2023, where this item was rated as one of the aspects least in line with the IPS model. This could be due to the lack of openness and information on the part of employers, which does not encourage coaches to engage in dialogue with them. This underscores the need to emphasise adherence to IPS principles, but above all, to destigmatise mental disorders in the workplace. Fidelity to IPS, as well as the practices of coaches and the professional outcomes of clients, could thus improve.

On a broader level, The Swiss Invalidity Insurance has recently launched a campaign to promote mental health in the workplace, where all the illustrations from this thesis come from (Office de l'assurance-invalidité pour le canton de Vaud,

2022; SVA Zürich, 2018). As part of this initiative, new services are available: A helpline redirects employers seeking information or expressing concerns about a colleague's mental health, for example. A freely downloadable brochure provides employers with practical tools for detecting challenging situations and implementing follow-up interviews to support the affected employee. Small and medium-sized businesses can request a free status check to assess their level of development of positive mental health in the workplace. Finally, awareness workshops aimed at supporting good mental health can be organised within companies. This is beneficial as the implemented adaptations and the support of employers and colleagues contribute to the job retention of individuals with mental disorders (Corbière, Villotti, Lecomte, et al., 2014; Corbière, Villotti, Toth, et al., 2014; Huff et al., 2008).

IPS, GPM and this thesis contribute to different levels of destigmatisation. This issue is at the heart of community psychiatry, but it also resonates with schools, business, healthcare, etc., by reaching out to various audiences from the general population. Numerous other initiatives in this direction exist. In Vaud, Switzerland, since 2022, the Mental Health Month takes place from September 10 to October 10 and includes diverse activities: Mad Pride, exhibitions, conferences, awareness workshops, film screenings, theatre performances, flash mobs. All aim to inform and raise awareness about mental health, as well as give visibility to available resources for supporting affected individuals. Our research is therefore in line with present-day discussions. All these initiatives can contribute to reducing stereotypes in the job market, healthcare teams, and among the service users themselves. They

contribute to facilitating the access of individuals with mental disorders to a successful integration into the community.

References

Ailam, L., Rchidi, M., Tortelli, A., & Skurnik, N. (2009). Le processus de désinstitutionnalisation [The de-institutionalization process]. *Annales Médico-Psychologiques, 167*(6), 455–458. https://doi.org/10.1016/j.amp.2009.05.001

Alverson, M., Becker, D. R., & Drake, R. E. (1995). An ethnographic study of coping strategies used by people with severe mental illness participating in supported employment. *Psychosocial Rehabilitation Journal, 18*(4), 115–128. https://doi.org/10.1037/h0095476

American Psychiatric Association. (2001). Practice guideline for the treatment of patients with borderline personality disorder. *American Journal of Psychiatry, 158*, 1—52.

American Psychiatric Association. (2015). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Amundsen Østby, K., Czajkowski, N., Knudsen, G. P., Ystrom, E., Gjerde, L. C., Kendler, K. S., Ørstavik, R. E., & Reichborn-Kjennerud, T. (2014). Personality disorders are important risk factors for disability pensioning. *Social Psychiatry and Psychiatric Epidemiology, 49*(12), 2003–2011. https://doi.org/10.1007/s00127-014-0878-0

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. https://doi.org/10.1037/h0095655

Arntz, A., Mensink, K., Cox, W. R., Verhoef, R. E. J., van Emmerik, A. A. P., Rameckers, S. A., Badenbach, T., & Grasman, R. P. P. P. (2023). Dropout from psychological treatment for borderline personality disorder: A multilevel survival meta-analysis. *Psychological Medicine, 53*(3), 668–686. https://doi.org/10.1017/ S0033291722003634

Arveiller, J.-P., & Bouvet, C. (2018). La méthode IPS (Individual Placement and Support ou soutien à l'emploi) : Origines et pratiques [The IPS (Individual Placement and Support) method: Origins and practices]. *Pratiques en Santé Mentale, 3*, 27–34. https://doi.org/10.3917/psm.183.0027

Bachelard, M., Bonsack, C., Silva, B., Morandi, S., & Golay, P. (2023). Une patiente-chercheuse en psychiatrie : Le rôle de l'expérience vécue dans la production de savoirs [A patient-researcher in psychiatry: The role of lived experience in the production of knowledge].

Revue Médicale Suisse, 19(835), 1379–1381. https://doi.org/10.53738/REVMED.2023.19.835.1379

Baer, N., & Fasel, T. (2011). Collaborateurs “difficiles” [“Difficult” collaborators]. *Sécurité sociale CHSS, 4*, 194–198.

Bagge, C., Nickell, A., Stepp, S., Durrett, C., Jackson, K., & Trull, T. J. (2004). Borderline personality disorder features predict negative outcomes 2 years later. *Journal of Abnormal Psychology, 113*(2), 279–288. https://doi.org/10.1037/0021-843X.113.2.279

Bailey, A. J., & Finn, P. R. (2020). Borderline personality disorder symptom comorbidity within a high externalizing sample: Relationship to the internalizing-externalizing dimensional structure of psychopathology. *Journal of Personality Disorders, 34*(6), 814–826. https://doi.org/10.1521/pedi_2019_33_415

Balaratnasingam, S., & Janca, A. (2019). Recovery in borderline personality disorder: Time for optimism and focussed treatment strategies. *Current Opinion in Psychiatry, 33*(1), 57–61. https://doi.org/10.1097/YCO.0000000000000564

Barnicot, K., Katsakou, C., Marougka, S., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder – A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 123*(5), 327–338. https://doi.org/10.1111/j.1600-0447.2010.01652.x

Barrick, M. R., Mount, M. K., & Judge, T. A. (2001). Personality and performance at the beginning of the new millennium: What do we know and where do we go next? *Personality and Performance, 9*(1-2), 9–30. https://doi.org/10.1111/1468-2389.00160

Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-baed treatment*. Oxford University Press.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical nanagement for borderline personality disorder. *American Journal of Psychiatry, 166*, 1355001364. https://doi.org/0.1176/appi.ajp.2009.09040539

Bateman, A. W., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *The Lancet, 385*, 735–743. https://doi.org/10.1016/S0140-6736(14)61394-5

Becker, D., Whitley, R., Bailey, E. L., & Drake, R. E. (2007). Long-term employment trajectories among participants with severe mental illness in supported employment. *Psychiatric Services, 58*(7), 922–928. https://doi.org/10.1176/ps.2007.58.7.922

Becker, D. R., & Drake, R. E. (1993). *A working life: The Individual Placement and Support (IPS)*. New Hampshire-Dartmouth Psychiatry Research Center.

Becker, D. R., & Drake, R. E. (2003). *A working life for people with severe mental illness*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195131215.001.0001

Becker, D. R., Xie, H., McHugo, G. J., Halliday, J., & Martinez, R. A. (2006). What predicts supported employment program outcomes? *Community Mental Health Journal, 42*(3), 303–313. https://doi.org/10.1007/s10597-006-9037-8

Beckwith, H., Moran, P. F., & Reilly, J. (2014). Personality disorder prevalence in psychiatric outpatients: A systematic literature review. *Personality and Mental Health, 8*(2), 91–101. https://doi.org/10.1002/pmh.1252

Bedell, J. R., Draving, D., Parrish, A., Gervey, R., & Guastadisegni, P. (1998). A description and comparison of experiences of people with mental disorders in supported employment and paid prevocational training. *Psychiatric Rehabilitation Journal, 21*(3), 279–283. https://doi.org/10.1037/h0095301

Bejerholm, U., & Eklund, M. (2007). Occupational engagement in persons with schizophrenia: Relationships to self-related variables, psychopathology, and quality of life. *American Journal of Occupational Therapy, 61*, 21–32. https://doi.org/10.5014/ajot.61.1.21

Belcher, J. R. (1989). On becoming homeless: A study of chronically mentally ill persons. *Journal of Community Psychology, 17*(2), 173–185. https://doi.org/10.1002/1520-6629(198904)17:2<173::AID-JCOP2290170209>3.0.CO;2-6

Beryl, R., & Völlm, B. (2017). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and Mental Health, 12*(1), 25—37. https://doi.org/10.1002/pmh.1396

Besse, C., Silva, B., Dutoit, M., & Bonsack, C. (2016). Soutien individuel à l'emploi (IPS) vaudois [Vaud Individual Placement and Support (IPS)]. *Swiss Archives of Neurology, Psychiatry and Psychotherapy, 167*(7), 215–221. https://doi.org/10.4414/sanp.2016.00434

Black, D. W., Blum, N., Pfohl, B., & St. John, D. (2004). The STEPPS group treatment program for outpatients with borderline personality disorder. *Journal of Contemporary Psychotherapy, 34*(3), 193–210. https://doi.org/10.1023/B:JOCP.0000036630.25741.83

Black, D. W., Pfohl, B., Blum, N., McCornick, B., Allen, J., North, C. S., Phillips, K. A., Robins, C., Siever, L., Silk, K. R., Williams, J. B. W., & Zimmerman, M. (2011). Attitudes toward borderline personality disorder: A survey of 706 mental health clinicians. *CNS Spectrums, 16*(3), 67–74. https://doi.org/10.1017/S109285291200020X

Black, M. H., Milbourn, B., Desjardins, K., Sylvester, V., Parrant, K., & Buchanan, A. (2019). Understanding the meaning and use of occupational engagement: Finding from a scoping review. *British Journal of occupational therapy, 82*(5), 272–287. https://doi.org/10.1177/0308022618821580

Blay, M., Benmakhlouf, I., Duarte, M., Perroud, N., Greiner, C., Charbon, P., Choi-Kain, L., & Speranza, M. (2023). Case reports: Using Good Psychiatric Management (GPM) conceptualizations in the dimensional assessment and treatment of personality disorders. *Frontiers in Psychiatry, 14*(1186524), 1–7. https://doi.org/10.3389/fpsyt.2023.1186524

Blum, N., Bartels, N., St John, D., & Pfohl, B. (2002). *STEPPS: Systems training for emotional predictability and problem solving–Group treatment for borderline personality disorder*. Blum's Books.

Bohus, M., Kleindienst, N., Limberger, M. F., Strieglitz, R.-D., Domsalla, M., Chapman, A. L., Steil, R., Philipsen, A., & Wolf, M. (2009). The short version of the Borderline Symptom List (BSL-23): Development and initial data on psychometric properties. *Psychopathology, 42*(1), 32–39. https://doi.org/10.1159/000173701

Bond, G. R. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal, 27*(4), 345-359. https://doi.org/10.2975/27.2004.345.359

Bond, G. R., Becker, D., & Drake, R. E. (2011). Measurement of fidelity of implementation of evidence-based practices: Case example of the IPS fidelity scale. *Clinical Psychology: Science and Practice, 18*(2), 126–141. https://doi.org/10.1111/j.1468-2850.2011.01244.x

Bond, G. R., Dietzen, L. L., McGrew, J. H., & Miller, L. D. (1995). Accelerating entry into supported employment for persons with severe psychiatric disabilities. *Rehabilitation Psychology, 40*(2), 75–94. https://doi.org/10.1037/0090-5550.40.2.75

Bond, G. R., Drake, R. E., & Becker, D. R. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry, 11*(1), 32–39. https://doi.org/10.1016/j.wpsyc.2012.01.005

Bond, G. R., Drake, R. E., & Pogue, J. A. (2019). Expanding Individual Placement and Support to populations with conditions and disorders other than serious mental illness. *Psychiatric Services, 70*(6), 488–498. https://doi.org/10.1176/appi.ps.201800464

Bond, G. R., Peterson, A. E., Becker, D. R., & Drake, R. E. (2012). Validation of the revised Individual Placement and Support fidelity scale (IPS-25). *Psychiatric Services, 63*(8), 758–763. https://doi.org/10.1176/appi.ps.201100476

Bond, G. R., Resnick, S. G., Drake, R. E., Xie, H., McHugo, G. J., & Bebout, R. R. (2001). Does competitive employment improve nonvocational outcomes for people with severe mental illness? *Consulting and Clinical Psychology, 69*(3), 489–501. https://doi.org/10.1037//0022-006X.69.3.489

Bonnington, O., & Rose, D. (2014). Exploring stigmatisation among people diagnosed with either bipolar disorder or borderline personality disorder: A critical realist analysis. *Social Science & Medicine, 123*, 7–17. https://doi.org/10.1016/j.socscimed.2014.10.048

Bordin, E. S. (1979). The generalizability of the psychoanalytical concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*(3), 252–260. https://doi.org/10.1037/h0085885

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20*(6), 680–691. https://doi.org/10.1080/10503307.2010.504242

Boycott, N., Schneider, J., & McMurran, M. (2012). Additional interventions to enhance the effectiveness of Individual Placement and Support: A rapid evidence assessment. *Rehabilitation Research and Practice, 2012*(382420), 1–8. https://doi.org/10.1155/2012/382420

Bozzatello, P., Blua, C., Brasso, C., Rocca, P., & Bellino, S. (2023). The role of cognitive deficits in borderline personality disorder with early traumas: A mediation analysis. *Journal of Clinical Medicine, 12*(787), 1–12. https://doi.org/10.3390/jcm12030787

Braun, V., & Clarke, V. (2013). *Successful qualitative research : A practical guide for beginners*. SAGE Publications Ltd.

Burns, T., Catty, J., Becker, T., Drake, R. E., Fioritti, A., Knapp, M., Lauber, C., Rössler, W., Tomov, T., van Busschbach, J., White, S., & Wiersma, D. (2007). The effectiveness of supported employment for people with severe mental illness: A randomised controlled trial. *Lancet, 370*, 1146-1152. https://doi.org/10.1016/S0140-6736(07)61516-5

Burns, T., Catty, J., White, S., Becker, T., Koletsi, M., Fioritti, A., Rössler, W., Tomov, T., van Busschbach, J., Wiersma, D., & Lauber, C. (2009). The impact of supported employment and working on clinical and social functioning: Results of an international study of Individual Placement and Support. *Schizophrenia Bulletin, 35*(5), 949–958. https://doi.org/10.1093/schbul/sbn024

Burns, T., Yeeles, K., Langford, O., Vazquez Montes, M., Burgess, J., & Anderson, C. (2015). A randomised controlled trial of time-limited individual placement and support: IPS-LITE trial. *The British Journal of Psychiatry, 207*, 351–356. https://doi.org/10.1192/bjp.bp.114.152082

Chanen, A. M., Nicol, K., Betts, J., Bond, G. R., Mihalopoulos, C., Jackson, H. J., Thompson, K. N., Jovev, M., Yuen, H. P., Chinnery, G., Ring, J., Allott, K., McCutcheon, L., Salmon, A. P., & Killackey, E. (2020). INdividual Vocational and Educational Support Trial (INVEST) for young people with borderline personality disorder: Study protocol for a randomised controlled trial. *Trials, 21*(583), 1–12. https://doi.org/10.1186/s13063-020-04471-3

Clark, L. A. (2007). Assessment and diagnosis of personality disorder: Perennial issues and emerging reconceptualization. *Annual Review of Psychology, 58*(1), 227–257. https://doi.org/10.1146/annurev.psych.57.102904.190200

Clarkin, J. F., Kernberg, O. F., & Yeomans, F. (1999). *Transference-focused psychotherapy for borderline personality disorder patients*. Guilford.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164*(6), 922–928. https://doi.org/10.1176/ajp.2007.164.6.922

Cleary, M., Siegfried, N., & Walter, G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing, 11*(3), 186–191. https://doi.org/10.1046/j.1440-0979.2002.00246.x

Commons Treolar, A. J. (2009). A qualitative investigation of the clinician experience of working with borderline personality disorder. *New Zealand Journal of Psychology, 38*(2), 30–34.

Comtois, K. A., Holland Kebrat, A., Atkins, D. C., Harned, M. S., & Edwood, L. (2010). Recovery from disability for individuals with borderline personality disorder: A feasibility trial of DBT-ACES. *Psychiatric Services, 61*(11), 1106–1111. https://doi.org/10.1176/ps.2010.61.11.1106

Corbière, M., & Lanctôt, N. (2011). Salient components in supported employment programs: Perspectives from employment specialists and clients. *Work, 39*(4), 427–439. https://doi.org/10.3233/WOR-2011-1192

Corbière, M., Lecomte, T., Reinharz, D., Kirsch, B., Goering, P., Menear, M., Berbiche, D., Genest, K., & Goldner, E. M. (2017). Predictors of acquisition of competitive employment for people enrolled in supported employment programs. *Journal of Nervous and Mental Disease, 205*(4), 275–282. https://doi.org/10.1097/NMD.0000000000000612

Corbière, M., Villotti, P., Berbiche, D., & Lecomte, T. (2023). Predictors of job tenure for people with a severe mental illness, enrolled in supported employment programs. *Psychiatric Rehabilitation Journal*. https://doi.org/10.1037/prj0000589

Corbière, M., Villotti, P., Lecomte, T., Bond, G. R., Lesage, A., & Goldner, E. M. (2014). Work accomodations and natural supports for maintaining employemt. *Psychiatric Rehabilitation Journal, 37*(2), 90–98. https://doi.org/10.1037/prj0000033

Corbière, M., Villotti, P., Toth, K., & Waghorn, G. (2014). Disclosure of a mental disorder in the workplace and work accommodations: Two factors associated with job tenure of people with severe mental disorders. *L'Encéphale, 40*, S91–S102. https://doi.org/10.1016/j.encep.2014.04.006

Corrigan, P. W., Kuwabara, S., Tsang, H., Shi, K., Larson, J., Lam, C. S., & Jin, S. (2008). Disability and work-related attitudes in employers from Beijing, Chicago, and Hong Kong. *International Journal of Rehabilitation Research, 31*(4). https://doi.org/10.1097/MRR.0b013e3282fb7d61

Corrigan, P. W., Powell, K. J., & Rüsch, N. (2012). How does stigma affect work in people with serious mental illnesses? *Psychiatric Rehabilitation Journal, 35*(5), 381–384. https://doi.org/10.1037/h0094497

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology, 11*(100), 1–9. https://doi.org/10.1186/1471-2288-11-100

Dahl, K., Larivière, N., & Corbière, M. (2017). Work participation of individuals with borderline personality disorder: A multiple case study. *Journal of Vocational Rehabilitation, 46*(3), 377–388. https://doi.org/10.3233/JVR-170874

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine of just a new bottle? *Professional Psychology: Research and Practice, 36*(5), 480–487. https://doi.org/10.1037/0735-7028.36.5.480

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459–470. https://doi.org/10.1080/09638230701482394

de Freixo Ferreira, L., Guerra, C., & Vieira-Coelho, M. A. (2023). Predictors of psychotherapy dropout in patients with borderline personality disorder: A systematic review. *Clinical Psychology & Psychotherapy*. https://doi.org/10.1002/cpp.2888

De Meulemeester, C., Lowyck, B., & Luyten, P. (2021). The role of impairments in self–other distinction in borderline personality disorder: A narrative review of recent evidence. *Neuroscience and Biobehavioral Reviews, 127*, 242–254. https://doi.org/10.1016/j.neubiorev.2021.04.022

Dean, B. B., Gerner, D., & Gerner, R. H. (2004). A systematic review evaluating health-related quality of life, work impairment, and healthcare costs and utilization in bipolar disorder. *Current Medical Research and Opinion, 20*(2), 139–154. https://doi.org/10.1185/030079903125002801

Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemporary Nurse, 21*(1), 43–49. https://doi.org/10.5172/conu.2006.21.1.43

Deegan, P. E. (2002). Recovery as a self-directed process of healing and transformation. *Occupational Therapy in Mental Health 17*(3–4), 5–21. https://doi.org/10.1300/J004v17n03_02

Demjaha, A., Valmaggia, L., Stahl, D., & McGuire, P. (2012). Disorganization/cognitive and negative symptom dimensions in the at-risk mental state predict subsequent transition to psychosis. *Schizophrenia Bulletin, 38*(2), 351–359. https://doi.org/10.1093/schbul/sbq088

Desai, V. S., Camp, C. L., & Krych, A. J. (2019). What Is the hierarchy of clinical evidence? In V. Musahl, J. Karlsson, M. T. Hirschmann, O. R. Ayeni, R. G. Marx, J. L. Koh, & N. Nakamura (Eds.), *Basic methods handbook for clinical orthopaedic research: A practical guide and case based research approach* (pp. 11–22). Springer. https://doi.org/10.1007/978-3-662-58254-1_2

Dewa, C. S., Loong, D., Trojanowski, L., & Bonato, S. (2018). The effectiveness of augmented versus standard individual placement and support programs in terms of employment: A systematic literature review. *Journal of Mental Health, 27*(2), 174–183. https://doi.org/10.1080/09638237.2017.1322180

Drake, R., & Bond, G. R. (2011). IPS support employment: A 20-year update. *American Journal of Psychiatric Rehabilitation, 14*(3), 155–164. https://doi.org/10.1080/15487768.2011.598090

Drozek, R. P. (2019). Social workers. In L. W. Choi-Kain & J. G. Gunderson (Eds.), *Applications of Good Psychiatric Management for borderline personality disorder : A practical guide* (pp. 141–167). American Psychiatric Association Publishing.

Dubreucq, J., Plasse, J., Gabayet, F., Faraldo, M., Blanc, O., Chereau, I., Cervello, S., Couhet, G., Demily, C., Guillard-Bouhet, N., Gouache, B., Jaafari, N., Legrand, G., Legros-Lafarge, E., Pommier, R., Quilès, C., Straub, D., Verdoux, H., Vignaga, F., Massoubre, C., REHABAse Network, & Franck, N. (2020). Self-stigma in serious mental illness and autism spectrum disorder: Results from the REHABase national psychiatric rehabilitation cohort. *European Psychiatry, 63*(1), 1–9. https://doi.org/10.1192/j.eurpsy.2019.12

Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (2023). Individual placement and support effectiveness for personality disorders compared with other mental disorders: A retrospective study. *Swiss Archives of Neurology, Psychiatry and Psychotherapy, 174*(1). https://doi.org/10.4414/sanp.2023.03301

Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (2024). Good Psychiatric Management for borderline personality disorder: A qualitative study of its implementation

in a supported employment team. *PLoS ONE, 19*(3), 1–14. https://doi.org/10.1371/journal.pone.0299514

Dunand, N., Golay, P., Bonsack, C., Spagnoli, D., & Pomini, V. (accepted). « Good Psychiatric Management » pour le trouble de la personnalité borderline dans le cadre du soutien à l'emploi : Étude de cas multiples sur l'expérience des clients [Good Psychiatric Management for borderline personality disorder in supported employment: A multiple case study of clients' experiences]. *Annales Médico-Psychologiques*.

Dunand, N., Seydoux, M., Teixeira Magalhaes, M., Bonsack, C., Golay, P., Spagnoli, D., & Pomini, V. (2024). Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: A qualitative study. *Heliyon, 10*(12), 1–11. https://doi.org/10.1016/j.heliyon.2024.e32955

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3–4), 327–350. https://doi.org/10.1007/s10464-008-9165-0

Dutoit, M., Spagnoli, D., & Besse, C. (2017). Une expérience suisse de soutien à l'emploi pour personnes souffrant des troubles psychiques [A Swiss experience of supported employment for people with mental health problems]. *Psychiatrie & Neurologie, 2*, 13–15.

Ekiz, E., van Alphen, S. P. J., Ouwens, M. A., Van de Paar, J., & Videler, A. C. (2022). Systems Training for Emotional Predictability and Problem Solving for borderline personality disorder: A systematic review. *Personality and Mental Health, 17*(1), 20–39. https://doi.org/10.1002/pmh.1558

Elliott, B., & Konet, R. J. (2014). The Connections Place: A job preparedness program for individuals with borderline personality disorder. *Community Mental Health Journal, 40*, 41–45. https://doi.org/10.1007/s10597-013-9601-y

Ettner, S. L., Maclean, J. C., & French, M. T. (2011). Does having a dysfunctional personality hurt your career? Axis II personality disorders and labor market outcomes. *Industrial Relations, 50*(1), 149–173. https://doi.org/10.1111/j.1468-232X.2010.00629.x

Farkas, M. D., & Anthony, W. A. (1989). *Psychiatric rehabilitation programs: Putting theory into practice*. Johns Hopkins University Press.

Faulkner, A. (2012). Participation and service user involvement. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 39–54). Wiley. https://doi.org/10.1002/9781119973249

Faulkner, A., & Thomas, P. (2002). User-led research and evidence-based medicine. *British Journal of Psychiatry, 180*(1), 1–3. https://doi.org/10.1192/bjp.180.1.1

Favre, C., Spagnoli, D., & Pomini, V. (2014). Dispositif de soutien à l'emploi pour patients psychiatriques : Évaluation rétrospective [Supported employment for psychiatric patients: Retrospective evaluation]. *Swiss Archives of Neurology and Psychiatry, 165*(7), 258–264. https://doi.org/10.4414/sanp.2014.00292

Favre, S., & Richard-Lepouriel, H. (2022). Stigmatisation et autostigmatisation dans les maladies psychiatriques : Enjeux et pratiques actuels. *Revue Médicale Suisse, 18*(796), 1749–1752. https://doi.org/10.53738/REVMED.2022.18.796.1749

Feigenbaum, J. D. (2019). Dialectical behavioural therapy skills for employment. In E. D. Swales (Ed.), *The Oxford handbook of dialectical behaviour therapy* (pp. 735–768). Oxford University Press.

Finch, E. F., Choi-Kain, L. W., Iliakis, E. A., Eisen, J., & Pinto, A. (2021). Good Psychiatric Management for obsessive–compulsive personality disorder. *Current Behavioral Neuroscience Reports, 8*(4), 160–171. https://doi.org/10.1007/s40473-021-00239-4

Folesani, F., Belvederi Murri, M., Biancosino, B., Costa, S., Zerbinati, L., Caruso, R., Nanno, M. G., Toffanin, T., Ferrara, M., Purdon, S. E., & Grassi, L. (2022). The screen for cognitive impairment in psychiatry in patients with borderline personality disorder. *Personality and Mental Health, 16*(4), 279–289. https://doi.org/10.1002/pmh.1539

Forsyth, A. (2007). The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing, 14*(1), 33–40. https://doi.org/10.1111/j.1365-2850.2007.01036.x

Frederick, D. E., & VanderWeele, T. J. (2019). Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. *PLoS ONE, 14*(2), 1–26. https://doi.org/10.1371/journal.pone.0212208

Gad, M. A., Pucker, H. E., Hein, K. E., Temes, C. M., Frankenburg, F. R., Fitzmaurice, G. M., & Zanarini, M. C. (2019). Facets of identity disturbance reported by patients with borderline

personality disorder and personality-disordered comparison subjects over 20 years of prospective follow-up. *Psychiatry Research, 271*, 76–82. https://doi.org/10.1016/j.psychres.2018.11.020

Galvez-Merlin, A., Lopez-Villatoro, J. M., de la Higuera-Gonzalez, P., de la Torre-Luque, A., Reneses-Prieto, B., Diaz-Marsa, M., & Carrasco, J. L. (2024). Social cognition deficits in borderline personality disorder: Clinical relevance. *Psychiatry Research, 331*(115675), 1–6. https://doi.org/10.1016/j.psychres.2023.115675

Gammelgaard, I., Christensen, T. N., Eplov, L. F., Jensen, S. B., Stenager, E., & Petersen, K. S. (2017). 'I have potential': Experiences of recovery in the individual placement and support intervention. *International Journal of Social Psychiatry, 63*(5), 400–406. https://doi.org/10.1177/0020764017708801

Ghanem, M., El-Serafi, D., Sabry, W., ElRasheed, A. H., Razek, G. A., Soliman, A., & Amar, W. (2016). Executive dysfunctions in borderline personality disorder: correlation with suicidality and impulsivity. *Middle East Current Psychiatry, 23*(2), 85–92. https://doi.org/10.1097/01.XME.0000481457.55394.66

Gilmour, H., & Pattern, S. B. (2007). Depression and work impairment. *Health Reports, 18*(1), 9—22.

Golay, P., Laloyaux, J., Moga, M., Della Libera, C., Frank, L., & Bonsack, C. (2020). Psychometric investigation of the French version of the Aberrant Salience Inventory (ASI): Differentiating patients with psychosis, patients with other psychiatric diagnoses and non-clinical participants. *Annals of General Psychiatry, 19*(58), 1–10. https://doi.org/10.1186/s12991-020-00308-0

Golay, P., Morandi, S., Silva, B., Devas, C., & Bonsack, C. (2019). Feeling coerced during psychiatric hospitalization: Impact of perceived status of admission and perceived usefulness of hospitalization. *International Journal of Law and Psychiatry, 67*(101512), 1–6. https://doi.org/10.1016/j.ijlp.2019.101512

González, J., Cortina, C., & Rodríguez, J. (2018). The role of gender stereotypes in hiring: A field experiment. *European Sociological Review, 35*(2), 187–204. https://doi.org/10.1093/esr/jcy055

Grasset, F. (2004). Réhabilitation psychosociale dans le domaine de la psychiatrie: Une discipline à la croisée des chemins [Psychosocial rehabilitation in psychiatry: A discipline at a crossroads]. *Revue Médicale de la Suisse Romande, 124*(4), 181.

Gratz, K. L., & Gunderson, J. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37*(1), 25–35. https://doi.org/10.1016/j.beth.2005.03.002

Gratz, K. L., Tull, M. T., & Levy, R. (2014). Randomized controlled trial and uncontrolled 9-month follow-up of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder. *Psychological Medicine, 44*(10), 2099–2112. https://doi.org/10.1017/S0033291713002134

Green, M. F., Kern, R. S., & Heaton, R. K. (2004). Longitudinal studies of cognition and functional outcome in schizophrenia: Implications for MATRICS. *Schizophrenia Research, 72*(1), 41–51. https://doi.org/10.1016/j.schres.2004.09.009

Gualtieri, C. T., & Morgan, D. W. (2008). The frequency of cognitive impairment in patients with anxiety, depression, and bipolar disorder: An unaccounted source of variance in clinical trials. *Journal of Clinical Psychiatry, 69*(7), 1122–1130. https://doi.org/10.4088/jcp.v69n0712

Guest, G., Bunce, A., & Laura, J. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 58–82. https://doi.org/10.1177/1525822X05279903

Gunderson, J. G., Herpertz, S. C., Skodol, A. E., Torgersen, S., & Zanarini, M. C. (2018). Borderline personality disorder. *Nature Reviews Disease Primers, 4*(18029), 1–20. https://doi.org/10.1038/nrdp.2018.29

Gunderson, J. G., & Links, P. S. (2014). *Handbook of Good Psychiatric Management for Borderline Personality Disorder*. American Psychiatric Association Publishing.

Gunderson, J. G., Masland, S., & Choi-Kain, L. W. (2018). Good Psychiatric Management: A review. *Current Opinion in Psychology, 21*, 127–131. https://doi.org/10.1016/j.copsyc.2017.12.006

Gyamfi, N., Bhullar, N., Islam, M. S., & Usher, K. (2022). Models and frameworks of mental health recovery: A scoping review of the available literature. *Journal of Mental Health, 10*, 1–13. https://doi.org/10.1080/09638237.2022.2069713

Hampson, M. E., Watt, B. D., & Hicks, R. E. (2020). Impacts of stigma and discrimination in the workplace on people living with psychosis. *BMC Psychiatry, 20*(288), 1–11. https://doi.org/10.1186/s12888-020-02614-z

Hastrup, L. H., Jennum, P., Ibsen, R., Kjellberg, J., & Soimonsen, E. (2019). Societal costs of Borderline Personality Disorders: A matched-controlled nationwide study of patients and spouses. *Acta Psychiatrica Scandinavica, 140*, 458–467. https://doi.org/10.1111/acps.13094

Heinrichs, R. W., & Zakzanis, K. K. (1998). Neurocognitive deficit in schizophrenia: A quantitative review of the evidence. *Neuropsychology, 12*(3), 426–445. https://doi.org/10.1037/0894-4105.12.3.426

Henderson, M., Harvey, S. B., Øverland, S., Mykleteun, A., & Hotopf, M. (2011). Work and common psychiatric disorders. *Journal of the Royal Society of Medicine, 104*(5), 198–207. https://doi.org/10.1258/jrsm.2011.100231

Hengartner, M. P., Müller, M., Rodgers, S., Rössler, W., & Ajdacic-Gross, V. (2014). Occupational functioning and work impairment in association with personality disorder trait-scores. *Social Psychiatry and Psychiatric Epidemiology, 49*, 327–335. https://doi.org/10.1007/s00127-013-0739-2

Hennessey, M., & McReynolds, C. J. (2001). Borderline personality disorder: Psychosocial considerations and rehabilitation implications. *Work, 17*(2), 97–103.

Hill, C., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S., A., & Ladany, N. (2005). Consensual Qualitative Research: An update. *Journal of Counseling Psychology, 52*(2), 196–205. https://doi.org/10.1037/0022-0167.52.2.196

Hoffman Judd, P. (2005). Neurocognitive impairment as a moderator in the development of borderline personality disorder. *Development and Psychopathology, 17*(4), 1173–1196. https://doi.org/10.1017/s0954579405050558

Hoffmann, H., Jäckel, D., Glauser, S., & Kupper, Z. (2012). A randomised controlled trial of the efficacy of supported employment. *Acta Psychiatrica Scandinavica, 125*, 157–167. https://doi.org/10.1111/j.1600-0447.2011.01780.x

Hoffmann, H., Jäckel, D., Glauser, S., Mueser, K. T., & Kupper, Z. (2014). Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. *American*

Journal of Psychiatry, 171(11), 1183–1190. https://doi.org/10.1176/appi.ajp.2014.13070857

Hopwood, C. J., Kotov, R., Krueger, R. F., Watson, D., Widiger, T. A., Althoff, R. R., Ansell, E. B., Bach, B., Bagby, R. M., Blais, M. A., Bornovalova, M. A., Chmielewski, M., Cicero, D. C., Conway, C., De Clercq, B., De Fruyt, F., Docherty, A. R., Eaton, N. R., Edens, J. F., Forbes, M. K., Forbush, K. T., Hengartner, M. P., Ivanova, M. Y., Leising, D., Livesley, W. J., Lukowitsky, M. R., Lynam, D. R., Markon, K. E., Miller, J. D., Morey, L. C., Mullins-Sweatt, S. N., Ormel, J. H., Patrick, C. J., Pincus, A. L., Ruggero, C., Samuel, D. B., Sellbom, M., Slade, T., Tackett, J. L., Thomas, K. M., Trull, T. J., Vachon, D. D., Waldman, I. D., Waszczuk, M. A., Waugh, M. H., Wright, A. G. C., Yalch, M. M., Zald, D. H., & Zimmerman, J. (2018). The time has come for dimensional personality disorder diagnosis. *Personality and Mental Health, 12*(1), 82–86. https://doi.org/10.1002/pmh.1408

Huff, S. W., Rapp, C. A., & Campbell, S. R. (2008). "Every day is not always jell-o": A qualitative study of factors affecting job tenure. *Psychiatric Rehabilitation Journal, 31*(3), 211–218. https://doi.org/10.2975/31.3.2008.211.218

Iliakis, E. A., Silva Ilagan, G., & Choi-Kain, L. W. (2021). Dropout rate from psychotherapy trials for borderline personality disorder: A meta-analysis. *Personality Disorders: Theory, Research, and Treatment, 12*(3), 193–206. https://doi.org/10.1037/per0000453

James, P. D., & Cowman, S. (2007). Psychiatric nurses' knowledge, experience and attitudes towards clients with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 14*(7), 670–678. https://doi.org/10.1111/j.1365-2850.2007.01157.x

Javaras, K. N., Zanarini, M. C., Hudson, J. I., Greenfield, S. F., & Gunderson, J. G. (2017). Functional outcomes in community-based adults with borderline personality disorder. *Journal of Psychiatric Research, 89*, 105–114. https://doi.org/10.1016/j.jpsychires.2017.01.010

Jeffreys, H. (1961). *Theory of probability* (3rd ed.). Clarendon.

Jeong, D., Aggarwal, S., Robinson, J., Kumar, N., Spearot, A., & Park, D. S. (2023). Exhaustive or exhausting? Evidence on respondent fatigue in long surveys. *Journal of Development Economics, 161*, 1–20. https://doi.org/10.1016/j.jdeveco.2022.102992

Jobst, A., Hörz, S., Birkhofer, A., Martius, P., & Rentrop, M. (2010). Einstellung von Psychotherapeuten gegenüber der Behandlung von Patienten mit Borderline Persönlichkeitsstörung [Psychotherapists' attitudes towards the treatment of patients with

borderline personality disorder]. *Psychotherapie, Psychosomatik, Medizinische Psychologie, 60*(3–4), 126–131. https://doi.org/10.1055/s-0029-1220764

Jovev, M., & Jackson, H. J. (2006). The relationship of borderline personality disorder, life events and functioning in an Australian psychiatric sample. *Journal of Personality Disorders, 20*(3), 205–217. https://doi.org/10.1521/pedi.2006.20.3.205

Juurlink, T. T., Lamers, F., van Marle, H. J. F., Michon, H., van Busschbach, J. T., Beekman, A. T. F., & Anema, J. R. (2020). Employment in personality disorders and the effectiveness of Individual Placement and Support. *Journal of Occupational Rehabilitation, 30*, 255–262. https://doi.org/10.1007/s10926-019-09868-9

Juurlink, T. T., Lamers, F., van Marle, H. J. F., Zwinkels, W., Spijkerman, A. T. F., Beekman, A. T. F., & Anema, J. R. (2022). Individual placement and support and employment in personality disorders: A registry based cohort study. *BMC Psychiatry, 22*(188), 1–9. https://doi.org/10.1186/s12888-022-03823-4

Juurlink, T. T., Vukadin, M., Stringer, B., Westerman, M. J., Lamers, F., Anema, J. R., Beekman, A. T. F., & van Marle, H. J. F. (2019). Barriers and facilitators to employment in borderline personality disorder: A qualitative study among patients, mental health practitioners and insurance physicians. *PLoS ONE, 14*(7), e0220233. https://doi.org/10.1371/journal.pone.0220233

Kaplan, B., Zazici Gulec, M., Gica, S., & Gulec, H. (2020). The association between neurocognitive functioning and clinical features of borderline personality disorder. *Brazilian Journal of Psychiatry, 42*(5), 503–509. https://doi.org/10.1590/1516-4446-2019-0752

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., & Priebe, S. (2012). Recovery in borderline personality disorder (BPD): A qualitative study of service users' perspectives. *PLoS ONE, 7*(5), e36517. https://doi.org/10.1371/journal.pone.0036517

Kealy, D., & Ogrodniczuk, J. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice, 16*(3), 145–154. https://doi.org/10.1097/01.pra.0000375710.39713.4d

Keuroghlian, A. S., Palmer, B. A., Choi-Kain, L. W., Borba, C. P. C., Links, P. S., & Gunderson, J. G. (2016). The effect of attenting Good Psychiatric Management (GPM) workshops on attitudes towards patients with borderline personality disorder. *Journal of Personality Disorders, 30*(40), 567–576. https://doi.org/10.1521/pedi_2015_29_206

Klein, J. P., Hauer-von Mauschwitz, A., Berger, T., Fassbinder, E., Mayer, J., Borgwardt, S., Wellhöfer, B., Schweiger, U., & Jacob, G. (2021). Effectiveness and safety of the adjunctive use of an internet-based self-management intervention for borderline personality disorder in addition to care as usual: Results from a randomised controlled trial. *BMJ Open, 11*(9), 1–9. https://doi.org/0.1136/bmjopen-2020-047771

Knaak, S., Szeto, A. C. H., Fitch, K., Modgill, G., & Patten, S. (2015). Stigma towards borderline personality disorder: effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. *Borderline Personality Disorder and Emotion Dysregulation*, 2–9. https://doi.org/10.1186/s40479-015-0030-0

Knudsen, A. K., Skogen, J. C., Harvey, S. B., Stewart, R., Hotopf, M., & Moran, P. (2012). Personality disorders, common mental disorders and receipt of disability benefits: Evidence from the British National Survey of Psychiatric Morbidity. *Psychological Medicine, 42*(1), 2631–2640. https://doi.org/10.1017/S0033291712000906

Koletsi, M., Niersman, A., van Busschbach, J. T., Catty, J., Becker, T., Burns, T., Fioritti, A., Kalkan, R., Lauber, C., Rössler, W., Tomov, T., & Wiersma, D. (2009). Working with mental health problems: Clients' experiences of IPS, vocational rehabilitation and employment. *Social Psychiatry and Psychiatric Epidemiology, 44*(11), 961–970. https://doi.org/10.1007/s00127-009-0017-5

Kolla, N. J., Links, P. S., McMain, S., Streiner, D. L., Cardish, R. J., & Cook, M. (2009). Demonstrating adherence to guidelines for the treatment of patients with borderline personality disorder. *The Canadian Journal of Psychiatry, 54*(3), 181–189. https://doi.org/10.1177/070674370905400306

Koons, C. R., Chapman, A. L., Betts, B. B., O'Rourke, B., Morse, N., & Robins, C. J. (2006). Dialectical behavior therapy adapted for the vocational rehabilitation of significantly disabled mentally ill adults. *Cognitive and Behavioral Practice, 13*(2), 146–156. https://doi.org/10.1016/j.cbpra.2005.04.003

Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzalez, A. M., Q., M. J., Bishop, G. G., Butterfield, M. I., & Bastian, L. A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 32*(2), 371–390. https://doi.org/10.1016/S0005-7894(01)80009-5

Korkeila, J., Oksanen, T., Virtanen, M., Salo, P., Nabi, H., Pentti, J., Vahtera, J., & Kivimäki, M. (2011). Early retirement from work among employees with a diagnosis of personality disorder compared to anxiety and depressive disorders. *European Psychiatry, 26*(1), 18–22. https://doi.org/10.1016/j.eurpsy.2009.12.022

Kosyluk, K. A., Corrigan, P. W., & Landis, R. S. (2014). Employer stigma as a mediatior between past and future hiring behavior. *Rehabilitation Counseling Bulletin, 57*(2), 102–108. https://doi.org/10.1177/0034355213496284

Kovanicova, M., Kubasovska, Z., & Pallayova, M. (2020). Exploring the presence of personality disorders in a sample of psychiatric inpatients. *Journal of Psychiatry and Psychiatric Disorders, 4*(3), 118–129. https://doi.org/10.26502/jppd.2572-519X0099

Kramer, U., Temes, C. M., Frankenburg, F. R., Glass, I. V., & Zanarini, M. C. (2023). Course and predictors of social security disability insurance in patients with borderline personality disorder over 24 years of prospective follow-up. *Borderline Personality Disorder and Emotion Dysregulation, 10*(30), 1–10. https://doi.org/10.1186/s40479-023-00236-x

Krawitz, R., & Batcheler, M. (2006). Borderline personality disorder: A pilot survey about clinician views on defensive practice. *Australasian Psychiatry, 14*(3), 320–322. https://doi.org/10.1111/j.1440-1665.2006.02297.x

Lanfredi, M., Ridolfi, M. E., Occhialini, G., Pedrini, L., Ferrari, C., Lasalvia, A., Gunderson, J. G., Black, D. W., Rossi, R., & Group, I. B. A. S. (2021). Attitudes of mental health staff toward patients with borderline personality disorder: An Italian cross-sectional multisite study. *Journal of Personality Disorders, 34*(1), 41–56. https://doi.org/10.1521/pedi_2019_33_421

Lang, U., & Hellweg, R. (2006). Prevalence and role of psychiatric disorders in disability. *Versicherungsmedizin, 58*(4), 164–169.

Laporte, L., Paris, J., Bergevin, T., Fraser, R., & Cardin, J.-F. (2018). Clinical outcomes of a stepped care program for borderline personality disorder. *Personality and Mental Health, 12*(3), 252–264. https://doi.org/10.1002/pmh.1421

Larivière, N., Couture, É., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S.-A., David, P., & St-Cyr-Tribble, D. (2015). Recovery, as experienced by women with borderline personality disorder. *Psychiatric Quarterly, 86*(4), 555–568. https://doi.org/10.1007/s11126-015-9350-x

Larivière, N., Dahl, K., & Corbière, M. (2022). Conception et modèle logique de l'intervention BIWI sur la réinsertion au travail de personnes avec un trouble de personnalité limite [Design and logic model of the BIWI intervention on work reintegration of people with borderline personality disorder]. *Santé mentale au Québec, 47*(2), 197–220. https://doi.org/10.7202/1098901ar

Larivière, N., Dahl, K., & Corbière, M. (2024). Pilot intervention of the newly developed Borderline Intervention for Work Integration (BIWI). *Journal of Psychosocial Rehabilitation and Mental Health*, 1–11. https://doi.org/10.1007/s40737-023-00385-w

Larson, J. E. (2008). User-friendly motivational interviewing and evidence-based supported employment tools for practitioners. *Journal of Rehabilitation, 74*(4), 18–30.

Lauber, C., & Bowen, J. L. (2010). Low mood and employment: When affective disorders are intertwined with the workplace–A UK perspective. *International Review of Psychiatry, 22*(2), 173–182. https://doi.org/10.3109/09540261003716405

Lenzenweger, M. F., Lane, M. C., Loranger, A. w., & Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*(6), 553–564. https://doi.org/10.1016/j.biopsych.2006.09.019

Liberman, R. P., & Kopelowicz, A. (2002). Recovery from schizophrenia: A challenge for the 21st century. *International Review of Psychiatry, 14*(4). https://doi.org/10.1080/0954026021000016897

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Korslund, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives Of General Psychiatry, 63*, 757–766. https://doi.org/10.1001/archpsyc.63.7.757

Links, P. S., Ross, J., & Gunderson, J. G. (2015). Promoting Good Psychiatric Management for patients with borderline personality disorder. *Journal of Clinical Psychology, 71*(8), 753–763. https://doi.org/10.1002/jclp.22203

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health, 12*(6), 595–612. https://doi.org/10.1080/09638230310001627955

Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology, 42*(3), 243–256. https://doi.org/10.1348/01446650360703366

Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., George, P., & Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services, 65*(1), 16–23. https://doi.org/10.1176/appi.ps.201300262

Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment. *Social Psychiatry and Psychiatric Epidemiology, 39*, 337–349.

Marwaha, S., & Johnson, S. (2005). Views and experiences of employment among people with psychosis: A qualitative descriptive study. *International Journal of Social Psychiatry, 51*(4), 302–316. https://doi.org/10.1177/0020764005057386

Masland, S. R., Price, D., MacDonald, J., Finch, E., Gunderson, J. G., & Choi-Kain, L. W. (2018). Enduring effects of one-day training in Good Psychiatric Management on clinicial attitudes about borderline personality disorder. *The Journal of Nervous and Mental Disease, 206*(11), 865–869. https://doi.org/10.1097/NMD.0000000000000893

Mason, J. (2002). *Qualitative researching*. Sage.

McMain, S., Guimond, T., Streiner, D. L., Cardish, R. J., & Links, P. S. (2012). Dialectical behavior therapy compared with general psychiatric management for borderline personality disorder: Clinical outcomes and functioning over a 2-year follow-up. *American Journal of Psychiatry, 196*(6), 650–661. https://doi.org/10.1176/appi.ajp.2012.11091416

McMain, S., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1365–1374. https://doi.org/10.1176/appi.ajp.2009.09010039

McQuilken, M., Zahniser, J. H., Novak, J., Starks, R. D., Olmos, A., & Bond, G. R. (2003). The work project survey: Consumer perspectives on work. *Journal of Vocational Rehabilitation, 18*(1), 59–68.

Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology, 50*(3-4), 462–480. https://doi.org/10.1007/s10464-012-9522-x

Millner, U. C., Rogers, E. S., Bloch, P., Costa, W., Pritchett, S., Woods, T., Teixeira, C., & Hintz, K. (2022). Unpacking the meaning of work for individuals living with serious mental illness. *Journal of Career Development, 49*(2), 393–410. https://doi.org/10.1177/0894845320941256

Modini, M., Joyce, S., Mykleteun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australian Psychiatry, 24*(4), 331–336. https://doi.org/10.1177/1039856215618523

Modini, M., Tan, L., Brinchmann, B., Wang, M.-J., Killackey, E., Glozier, N., Mykletun, A., & Harvey, S. B. (2016). Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry, 209*(1), 14–22. https://doi.org/10.1192/bjp.bp.115.165092

Mueser, K. T., Bond, G. R., Essock, S. M., & Clark, R. E. (2014). The effects of supported employment in Latino consumers with severe mental illness. *Psychiatric Rehabilitation Journal, 37*(2), 113-122. https://doi.org/10.1037/prj0000062

Mueser, K. T., Salyers, M. P., & Mueser, P. R. (2001). A prospective analysis of work in schizophrenia. *Schizophrenia Bulletin, 27*(2), 281–296. https://doi.org/10.1093/oxfordjournals.schbul.a006874

Murray, L. L., Tol, W., Jordans, M., Zangana, G. S., Amin, A. M., Bolton, P., Bass, J., Bonilla-Escobar, F. J., & Thornicroft, G. (2014). Dissemination and implementation of evidence based, mental health interventions in post conflict, low resource settings. *Intervention (Amstelveen), 12*(1), 94–112. https://doi.org/10.1097/WTF.0000000000000070

Nasrallah, H. A. (2008). Bring back the asylums? The tragic consequences of deinstitutionalization. *Current Psychiatry, 7*(3), 19–20.

National Health Service. (2021). *Personal social services: Staff of social services departments*. https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-staff-of-social-services-departments/england-2020/individual-worker-characteristics

Newton-Howes, G., Weaver, T., & Tyrer, P. (2008). Attitudes of staff towards patients with personality disorder in community mental health teams. *Australian and New Zealand Journal of Psychiatry, 42*, 572–577. https://doi.org/10.1080/00048670802119739

Ng, F. Y. Y., Townsend, M. L., Miller, C. E., Jewell, M., & Grenyer, B. F. S. (2019). The lived experience of recovery in borderline personality disorder: A qualitative study. *Borderline Personality Disorder and Emotion Dysregulation, 6*(10), 1–9. https://doi.org/10.1186/s40479-019-0107-2

Nicastro, R., Prada, P., Kung, A.-L., Salamin, V., Dayer, A., Aubry, J.-M., Guenot, F., & Perroud, N. (2016). Psychometric properties of the French borderline symptom list, short form (BSL-23). *Borderline Personality Disorder and Emotion Dysregulation, 3*(4), 1–9. https://doi.org/10.1186/s40479-016-0038-0

Noël, Y. (2013). *AtelieR: A GTK GUI for teaching basic concepts in statistical inference, and doing elementary bayesian tests.* In *R package* (Version 0.24)

Noël, Y. (2015). *Psychologie statistique avec R* [Psychological statistics with R]. EDP sciences.

O'Donnell, L. A., Deldin, P. J., Grogan-Kaylor, A., McInnis, M. G., Weintraub, J., Ryan, K. A., & Himle, J. A. (2017). Depression and executive functioning deficits predict poor occupational functioning in a large longitudinal sample with bipolar disorder. *Journal of Affective Disorders, 215*, 135–142. https://doi.org/10.1016/j.jad.2017.03.015

OCDE. (2012). *Sick on the Job? Myths and Realities about Mental Health and Work*. Mental Health and Work, Éditions OCDE, Paris. https://doi.org/10.1787/9789264124523-en

OCDE. (2014). *Mental Health and Work: Switzerland*. Mental Health and Work, Éditions OCDE, Paris. https://doi.org/10.1787/9789264204973-1-en

OCDE. (2015). *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work, Mental Health and Work*. Mental Health and Work, Éditions OCDE, Paris. https://doi.org/10.1787/9789264228283-en

Ociskova, M., Prasko, J., Vanek, J., Nesnidal, V., Sollar, T., & Slepecky, M. (2023). Stigma and self-stigma in borderline personality disorder: A narrative review. *Neuroendocrinology Letters, 44*(4), 206–215.

OECD/EU. (2018). *Health at a Glance: Europe 2018: State of Health in the EU Cycle*. https://doi.org/10.1787/health_glance_eur-2018-en

Oei, T. P. S., & Green, A. L. (2008). The Satisfaction with Therapy and Therapist Scale–Revised (STTS–R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *Professional Psychology: Research and Practice, 39*(4), 435–442. https://doi.org/10.1037/0735-7028.39.4.435

Office de l'assurance-invalidité pour le canton de Vaud. (2022). *Santé mentale en entreprise*. https://sme.aivd.ch

Onwuegbuzie, A. J., & Collins, K. M. T. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report, 12*(2), 281–316. https://doi.org/10.46743/2160-3715/2007.1638

Østerud, K. L. (2023). Mental illness stigma and employer evaluation in hiring: Stereotypes, discrimination and the role of experience. *Sociology of Health & Illness, 45*(1), 90–108. https://doi.org/10.1111/1467-9566.13544

Paris, J. (2013). Stepped care: An alternative to routine extended treatment for patients with borderline personality disorder. *Psychiatric Services, 64*(10), 1035–1037. https://doi.org/10.1176/appi.ps.201200451

Pascual, J. C., Palomares, N., Ibáñez, Á., Portella, M. J., Arza, R., Reyes, R., Feliu-Soler, A., Díaz-Marsá, M., Saiz-Ruiz, J., Soler, J., & Carrasco, J. L. (2015). Efficacy of cognitive rehabilitation on psychosocial functioning in Borderline Personality Disorder: A randomized controlled trial. *BMC Psychiatry, 15*(255), 1–9. https://doi.org/10.1186/s12888-015-0640-5

Perreault, I. (2015). La folie, c'est de n'avoir pas d'autres normes que soi-même : La psychiatrie au cours de l'après-guerre au Québec [Madness is conforming to one's own norms, and no others: Psychiatry in post-war Quebec]. *Santé mentale au Québec, 40*(2). https://doi.org/10.7202/1033041ar

Potkin, S. G., Bugarski-Kirola, D., Edgar, C. J., Soliman, S., Le Scouiller, S., Kunovac, J., Velasco, E. M., & Garibaldi, G. M. (2016). Psychometric evaluation of the Work Readiness Questionnaire in schizophrenia. *CNS Spectrums, 21*(199-206), 199–206. https://doi.org/10.1017/S1092852914000352

Potvin, O., Vallée, C., & Larivière, N. (2019). Experience of occupations among people living with a personality disorder. *Occupational Therapy International, 2019*(9030897), 1–11. https://doi.org/10.1155/2019/9030897

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

Proctor, E. K., Landverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), 24–34. https://doi.org/10.1007/s10488-008-0197-4

Rasinski, K. A., Lee, L., & Krishnamurty, P. (2012). Question order effects. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology: Vol. 1. Foundations, planning, measures, and psychometrics* (pp. 229–248). American Psychological Association. https://doi.org/10.1037/13619-014

Reed, L. I., & Zanarini, M. C. (2011). Positive affective and cognitive states in borderline personality disorder. *Journal of Personality Disorders, 26*(6), 851–862. https://doi.org/10.1521/pedi.2011.25.6.851

Reich, J., Yates, W., & Nduaguba, M. (1989). Prevalence of DSM-III personality disorders in the community. *Social Psychiatry and Psychiatric Epidemiology, 24*, 12-16.

Rissmiller, D. J., & Rissmiller, J. H. (2006). Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatric Services, 57*(6), 863–866. https://doi.org/10.1176/ps.2006.57.6.863

Roepke, S., Vater, A., Preißler, S., Heekeren, H. R., & Dziobek, I. (2012). Social cognition in borderline personality disorder. *Frontiers in Neuroscience, 6*(195), 1–12. https://doi.org/10.3389/fnins.2012.00195

Rogers, A. J. (1995). Work is key to recovery. *Psychosocial Rehabilitation Journal, 18*(4), 5–10. https://doi.org/10.1037/h0095485

Rose, D. (2014). Patient and public involvement in health research: Ethical imperative and/or radical challenge? *Journal of Health Psychology, 19*(1), 149–158. https://doi.org/10.1177/1359105313500249

Saint-Arnaud, J. (2001). Désinstitutionnalisation et responsabilité de l'État dans l'accessibilité aux services en santé mentale au Québec. *Ethique Publique, 3*(1). https://doi.org/10.4000/ethiquepublique.2622

Samuel, D. B., & Widiger, T. A. (2010). A comparison of obsessive-compulsive personality disorder scales. *Journal of Personality Assessment, 92*(3), 232–240. https://doi.org/10.1080/00223891003670182

Sandage, S. J., Long, B., Moen, R., Jankowski, P. J., Worthington, E. L., Wade, N. G., & Rye, M. S. (2015). Forgiveness in the treatment of borderline personality disorder: A quasi-experimental study. *Journal of Clinical Psychology, 71*(7), 625–640. https://doi.org/10.1002/jclp.22185

Sanderson, K., & Andrews, G. (2006). Common mental disorders in the workforce: Recent findings from descriptive and social epidemiology. *The Canadian Journal of Psychiatry, 51*(2), 63–75. https://doi.org/10.1177/070674370605100202

Sansone, R. A., & Sansone, L. A. (2013). Responses of mental health clinicians to patients with borderline personality disorder. *Innovations in Clinical Neuroscience, 10*(5–6), 39–43.

Sansone, R. A., & Wiederman, M. W. (2013). Losing a job on purpose: Relationships with borderline personality symptomatology. *Early Intervention in Psychiatry, 7*, 210–212. https://doi.org/10.1111/eip.12014

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity, 52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Schuler, D., Tuch, A., Buscher, N., & Camenzind, P. (2016). *La santé psychique en Suisse. Monitorage 2016* (Obsan Rapport 72, Issue Neuchâtel: Observatoire suisse de la santé). N. O. s. d. l. santé.

Schuler, D., Tuch, A., & Peter, C. (2020). *La santé psychique en Suisse: Monitorage 2020* [Swiss Health Observatory](15/2020). (Swiss Health Observatory Report, Issue 15/2020).

Schulte Holthausen, B., & Habel, U. (2018). Sex differences in personality disorders. *Current Psychiatry Reports, 20*(107), 1–7. https://doi.org/10.1007/s11920-018-0975-y

Schuring, M., Robroek, S. J. W., & Burdorf, A. (2017). The benefits of paid employment among persons with common mental health problems: evidence for the selection and causation mechanism. *Scandinavian Journal of Work, Environment & Health, 43*(6), 540–549. https://doi.org/10.5271/sjweh.3675

Secker, J., Grove, B., & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: The service user's perspective. *Journal of Mental Health, 10*(4), 395–404. https://doi.org/10.1080/09638230120041155

Servais, L. M., & Saunders, S. M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice, 38*(2), 214–219. https://doi.org/10.1037/0735-7028.38.2.214

Shah, R., & Zanarini, M. C. (2018). Comorbidity of borderline personality disorder: Current status and future directions. *Psychiatric Clinics of North America, 41*(4), 583–593. https://doi.org/10.1016/j.psc.2018.07.009

Shinnar, A. P., Rothbard, A. B., Kanter, R., & Jung, Y. S. (1990). An empirical literature review of definitions of severe and persistent mental illness. *American Journal of Psychiatry, 147*(12), 1602–1608. https://doi.org/10.1176/ajp.147.12.1602

Sio, I. T., Chanen, A. M., Killackey, E. J., & Gleeson, J. (2011). The relationship between impulsivity and vocational outcome in outpatient youth with borderline personality features. *Early Intervention in Psychiatry, 5*, 249–253. https://doi.org/10.1111/j.1751-7893.2011.00271.x

Skodol, A. E. (2014). Personality disorder classification: Stuck in neutral, how to move forward? *Current Psychiatry Reports, 16*(480), 1–10. https://doi.org/10.1007/s11920-014-0480-x

Skodol, A. E., Bender, D. S., & Oldham, J. M. (2014). An alternative model for personality disorders: DSM-5 Section III and beyond. In J. M. Oldham, A. E. Skodol, & D. S. Bender (Eds.), *The American Psychiatric Publishing textbook of personality disorders* (pp. 511–544). American Psychiatric Publishing, Inc.

Skodol, A. E., Gunderson, J. G., McGlashan, T. H., Dyck, I. R., Stout, R. L., Bender, D. S., Grilo, C. M., She, M. T., Zanarini, M. C., Morey, L. C., Sanislow, C. A., & Oldham, J. M. (2002). Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *American Journal of Psychiatry, 159*, 276–283. https://doi.org/10.1176/appi.ajp.159.2.276

Skodol, A. E., Morey, L. C., Bender, D. S., & Oldham, J. M. (2015). The alternative DSM-5 model for personality disorders: A clinical application. *American Journal of Psychiatry, 172*(7), 606–613. https://doi.org/10.1176/appi.ajp.2015.14101220

Stalker, K., Ferguson, I., & Barclay, A. (2005). 'It is a horrible term for someone': Service user and provider perspectives on 'personality disorder'. *Disability & Society, 20*(4), 359–373. https://doi.org/10.1080/09687590500086443

Steuwe, C., Berg, M., Driessen, M., & Beblo, T. (2023). Therapeutic alliance and dropout in patients with borderline pathology receiving residential dialectical behavior therapy. *BMC Psychiatry, 23*(605), 1–10. https://doi.org/10.1186/s12888-023-05061-8

Stevenson, J., Meares, R., & Comerford, A. (2003). Diminished impulsivity in older patients with borderline personality disorder. *American Journal of Psychiatry, 160*(1), 165–166. https://doi.org/10.1176/appi.ajp.160.1.165

Strickler, D. C., Whitley, R., Becker, D. R., & Drake, R. E. (2009). First person accounts of long-term employment activity among people with dual diagnosis. *Psychiatric Rehabilitation Journal, 32*(4), 261–268. https://doi.org/10.2975/32.4.2009.261.268

Suijkerbuijk, Y. B., Schaafsma, F. G., van Mechelen, J. C., Ojajärvi, A., Corbière, M., & Anema, J. R. (2017). Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. *Cochrane Database of Systematic Reviews*(9), 1–195, Article CD003080. https://doi.org/10.1002/14651858.CD011867.pub2

Sulzer, S. H. (2015). Does "difficult patient" status contribute to de facto demedicalization? The case of borderline personality disorder. *Social Science and Medicine, 142*, 82–89. https://doi.org/10.1016/j.socscimed.2015.08.008

Sulzer, S. H., Muenchow, E., Potvin, A., Harris, J., & Gigot, G. (2016). Improving patient-centered communication of the borderline personality disorder diagnosis. *Journal of Mental Health, 25*(1), 5–9. https://doi.org/10.3109/09638237.2015.1022253

SVA Zürich. (2018). [Photograph illustrating that mental problems mask the true face]. https://svazurich.ch/ihr-anliegen/arbeitgebende/rund-um-die-iv/mitarbeitende-mit-gesundheitlichen-problemen-/frueherkennung.html

Svaldi, J., Philipsen, A., & Matthies, S. (2012). Risky decision-making in borderline personality disorder. *Psychiatry Research, 197*(1–2), 112–118. https://doi.org/10.1016/j.psychres.2012.01.014

Temes, C. M., & Zanarini, M. C. (2018). The longitudinal course of borderline personality disorder. *Psychiatric Clinics of North America, 41*(4), 685–694. https://doi.org/10.1016/j.psc.2018.07.002

Temes, C. M., & Zanarini, M. C. (2019). Recent developments in psychosocial interventions for borderline personality disorder. *F1000Research, 8*(561). https://doi.org/10.12688/f1000research.18561.1

Thompson, J. (2022). A guide to abductive thematic analysis. *The Qualitative Report, 27*(5), 1410–1421. https://doi.org/10.46743/2160-3715/2022.5340

Tyrer, P., Mulder, R., Crawford, M. J., Newton-Howes, G., Simonsen, E., Ndetei, D., Koldobsky, N., Fossati, A., Mbatia, J., & Barrett, B. (2010). Personality disorder: A new global perspective. *World Psychiatry, 2010*(9), 56–60. https://doi.org/10.1002/j.2051-5545.2010.tb00270.x

Tyrer, P., Reed, G. M., & Crawford, M. J. (2015). Classification, assessment, prevalence, and effect of personality disorder. *The Lancet, 385*(9969), 717–726. https://doi.org/10.1016/S0140-6736(14)61995-4

van Niekerk, L. (2009). Participation in work: A source of wellness for people with psychiatric disability. *Work, 32*(4), 455–465. https://doi.org/10.3233/WOR-2009-0856

Vázquez-Estupiñan, M. F., Durand-Arias, S., Astudillo-García, C. I., & Madrigal de León, E. Á. (2018). Effectiveness of augmented Individual Placement and Support interventions for competitive employment in people with schizophrenia: Systematic review and meta-analysis. *Salud Mental, 41*(4), 187–197. https://doi.org/10.17711/SM.0185-3325.2018.027

Viering, S., Jäger, M., & Kawohl, W. (2015). Welche Faktoren beeinflussen den Erfolg von Supported Employment? [What factors influence the success of supported employment?]. *Psychiatr Prax, 42*(6), 299–308. https://doi.org/10.1055/s-0034-1387695

Vincent, C., & Staines, A. (2019). *Enhancing the quality and safety of Swiss healthcare* Federal Office of Public Health). https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj_xOrrgoqDAxWyhf0HHXNGATQQFnoECA0QAQ&url=https%3A%2F%2Fwww.bag.admin.ch%2Fdam%2Fbag%2Fde%2Fdokumente%2Fkuv-leistungen%2Fqualitaetssicherung%2FEnhancing%2520the%2520Quality%2520and%2520Safety%2520of%2520Swiss%2520Healthcare-EN.pdf.download.pdf%2FEnhancing%2520the%2520Quality%2520and%2520Safety%2520of%2520Swiss%2520Healthcare-EN.pdf&usg=AOvVaw1qgMP2deamLy2lo27Ufl7j&opi=89978449

Vita, A., Deste, G., Barlati, S., Poli, R., Cacciani, P., De Peri, L., & Sacchetti, E. (2018). Feasibility and effectiveness of cognitive remediation in the treatment of borderline personality disorder. *Neuropsychological Rehabilitation, 28*(3), 416–428. https://doi.org/10.1080/09602011.2016.1148054

Volkert, J., Gablonski, T.-C., & Rabung, S. (2018). Prevalence of personality disorders in the general adult population in Western countries: Systematic review and meta-analysis. *The British Journal of Psychiatry, 213*(6), 709–715. https://doi.org/10.1192/bjp.2018.202

Wagenmakers, E.-J., Wetzels, R., Borsboom, D., & van der Maas, H. L. J. (2011). Why psychologists must change the way they analyze their data: The case of psi: Comment on Bem (2011). *Journal of Personality and Social Psychology, 100*(3), 426–432. https://doi.org/10.1037/a0022790

Wallace, S. S., Barak, G., Truong, G., & Parker, M. W. (2022). Hierarchy of evidence within the medical literature. *Hospital Pediatrics, 12*(8), 745–749. https://doi.org/10.1542/hpeds.2022-006690

Wandersman, A., & Florin, P. (2003). Community interventions and effective prevention. *American Psychologist, 58*(6–7), 441–448. https://doi.org/10.1037/0003-066X.58.6-7.441

Watson, D., Levin-Aspenson, H. F., Waszczuk, M. A., Conway, C. C., Dalgleish, T., Dretsch, M. N., Eaton, N. R., Forbes, M. K., Forbush, K. T., Hobbs, K. A., Michelini, G., Nelson, B. D., Sellbom, M., Slade, T., South, S. C., Sunderland, M., Waldman, I., Witthöft, M., Wright, A. G. C., Kotov, R., & Krueger, R. F. (2022). Validity and utility of Hierarchical Taxonomy of Psychopathology (HiTOP): III. Emotional dysfunction superspectrum. *World Psychiatry, 21*(1), 26–54. https://doi.org/10.1002/wps.20943

Widiger, T. A., & Mullins-Sweatt, S. N. (2010). Clinical utility of a dimensional model of personality disorder. *Professional Psychology: Research and Practique, 41*(6), 488–494. https://doi.org/10.1037/a0021694

Wilkinson-Ryan, T., & Westen, D. (2000). Identity disturbance in borderline personality disorder: An empirical investigation. *American Journal of Psychiatry, 157*(4), 528–541. https://doi.org/10.1176/appi.ajp.157.4.528

Woollaston, K., & Hixenbaugh, P. (2008). 'Destructive Whirlwind': nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 15*(9), 703–709. https://doi.org/10.1111/j.1365-2850.2008.01275.x

World Economic Forum. (2021). *Global Gender Gap Report*. http://reports.weforum.org/global-gender-gap-report-2021/dataexplorer.

World Health Organization. (2022). *ICD-11: International classification of diseases* (11th ed.). https://icd.who.int/

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Sage.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford.

Zanarini, M. C., Conkey, L. C., Temes, C. M., & Fitzmaurice, G. M. (2018). Randomized controlled trial of web-based psychoeducation for women with borderline personality disorder. *Journal of Clinical Psychiatry, 79*(3), 52–59. https://doi.org/10.4088/JCP.16m11153

Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A., & Reynolds, V. (1998). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry, 155*(12), 1657–1800. https://doi.org/10.1176/ajp.155.12.1733

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *American Journal of Psychiatry, 161*(11), 2108–2114. https://doi.org/10.1176/appi.ajp.161.11.2108

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry, 169*(5), 476–483. https://doi.org/10.1176/appi.ajp.2011.11101550

Zanarini, M. C., Frankenburg, F. R., Wedig, M. M., & Fitzmaurice, G. M. (2013). Cognitive experiences reported by patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry, 170*(6), 671–679. https://doi.org/10.1176/appi.ajp.2013.13010055

Zanarini, M. C., Jacoby, R. J., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2009). The 10-year course of social security disability income reported by patients with borderline personality disorder and axis II comparison subjects. *Journal of Personality Disorders, 23*(4), 346–356. https://doi.org/10.1521/pedi.2009.23.4.346

Zegarra-Valdivia, J. A., & Chino Vilca, B. N. (2019). Social cognition and executive function in borderline personality disorder: Evidence of altered cognitive processes. *Salud Mental, 42*(1). https://doi.org/10.17711/SM.0185-3325.2019.005

Zimmerman, M., Chelminsky, I., Young, D., Kristy, D., & Martinez, J. (2012). Does the presence of one feature of borderline personality disorder have clinical significance? Implications for dimensional ratings of personality disorders. *Journal of Clinical Psychiatry, 73*(1), 8–12. https://doi.org/10.4088/JCP.10m06784

Zimmerman, M., Galione, J. N., Chelminski, I., Young, D., Dalrymple, K., & Ruggero, C. J. (2010). Sustained unemployment in psychiatric outpatients with bipolar disorder: Frequency and association with demographic variables and comorbid disorders. *Bipolar Disorders, 12*(7), 720–726. https://doi.org/10.1111/j.1399-5618.2010.00869.x

Zimmerman, M., Martinez, J., Young, D., Chelminsky, I., & Dalrymple, K. (2012). Sustained unemployment in psychiatric outpatients with bipolar depression compared to major depressive disorder with comorbid borderline personality disorder. *Bipolar Disorders, 14*, 856-862. https://doi.org/10.1111/bdi.12014

Zimmerman, M., Morgan, T. A., & Stanton, K. (2018). The severity of psychiatric disorders. *World Psychiatry, 17*(3), 258–275. https://doi.org/10.1002/wps.20569

Zimmerman, M., Rotschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *The American Journal of Psychiatry, 162*(10), 1911–1918. https://doi.org/10.1176/appi.ajp.162.10.1911

Supplemental material

Interview original topic guide in French – Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: Version 1

Partie 1 : Suivi difficile avec client TP

1. Difficultés
1.1 Difficulté 1 : Pouvez-vous nous dire quelle est la difficulté la plus importante liée à vos suivis avec des clients TP ?
Difficulté du coach et exemple concret
Origines et explications de la difficulté
Moment d'apparition dans les suivis de la difficulté
Fréquence et durée de la difficulté
1.2 Autres difficultés présentes : Vous avez identifié cette difficulté dans vos suivis, est-ce qu'il y en a une autre ? (Si oui, reposer toutes les sous-questions du 1.1). Et redemander ensuite si encore une autre difficulté avec toutes les sous-questions jusqu'à que le coach dise qu'il n'y a pas d'autres difficultés.
2. Solutions
2.1 Solutions difficulté 1 : La difficulté la plus importante pour vous dans vos suivis avec des clients souffrant de TP était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ?
Solutions mises en place ou imaginées pour pallier cette difficulté
2.2 Solutions autres difficultés : Une deuxième difficulté pour vous était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ? (Reposer toutes les sous-questions du 2.1). Et faire ensuite la même chose pour les autres difficultés.
3. IPS
Programme IPS adapté pour les suivis de clients souffrant de TP selon vous ?
Adaptations du programme IPS possibles pour les suivis de clients souffrant de TP ?

Partie 2 : Suivi difficile avec client TMS

1. Difficultés
1.1 Difficulté 1 : Pouvez-vous nous dire quelle est la difficulté la plus importante liée à vos suivis avec des clients TMS ?
Difficulté du coach et exemple concret
Origines et explications de la difficulté
Moment d'apparition dans les suivis de la difficulté
Fréquence et durée de la difficulté
1.2 Autres difficultés présentes : Vous avez identifié cette difficulté dans vos suivis, est-ce qu'il y en a une autre ? (Si oui, reposer toutes les sous-questions du 1.1). Et redemander ensuite si encore une autre difficulté avec toutes les sous-questions jusqu'à que le coach dise qu'il n'y a pas d'autres difficultés.
2. Solutions
2.1 Solutions difficulté 1 : La difficulté la plus importante pour vous dans vos suivis avec des clients souffrant de TMS était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ?
Solutions mises en place ou imaginées pour pallier cette difficulté
2.2 Solutions autres difficultés : Une deuxième difficulté pour vous était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ? (Reposer toutes les sous-questions du 2.1). Et faire ensuite la même chose pour les autres difficultés.
3. IPS
Programme IPS adapté pour les suivis de clients souffrant de TMS selon vous ?
Adaptations du programme IPS possibles pour les suivis de clients souffrant de TMS ?

Interview original topic guide in French – Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: Version 2

Partie 1 : Suivi difficile avec client TMS

1. Difficultés
1.1 Difficulté 1 : Pouvez-vous nous dire quelle est la difficulté la plus importante liée à vos suivis avec des clients TMS ?
Difficulté du coach et exemple concret
Origines et explications de la difficulté
Moment d'apparition dans les suivis de la difficulté
Fréquence et durée de la difficulté
1.2 Autres difficultés présentes : Vous avez identifié cette difficulté dans vos suivis, est-ce qu'il y en a une autre ? (Si oui, reposer toutes les sous-questions du 1.1). Et redemander ensuite si encore une autre difficulté avec toutes les sous-questions jusqu'à que le coach dise qu'il n'y a pas d'autres difficultés.
2. Solutions
2.1 Solutions difficulté 1 : La difficulté la plus importante pour vous dans vos suivis avec des clients souffrant de TMS était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ?
Solutions mises en place ou imaginées pour pallier cette difficulté
2.2 Solutions autres difficultés : Une deuxième difficulté pour vous était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ? (Reposer toutes les sous-questions du 2.1). Et faire ensuite la même chose pour les autres difficultés.
3. IPS
Programme IPS adapté pour les suivis de clients souffrant de TMS selon vous ?
Adaptations du programme IPS possibles pour les suivis de clients souffrant de TMS ?

Partie 2 : Suivi difficile avec client TP

1. Difficultés
1.1 Difficulté 1 : Pouvez-vous nous dire quelle est la difficulté la plus importante liée à vos suivis avec des clients TP ?
Difficulté du coach et exemple concret
Origines et explications de la difficulté
Moment d'apparition dans les suivis de la difficulté
Fréquence et durée de la difficulté
1.2 Autres difficultés présentes : Vous avez identifié cette difficulté dans vos suivis, est-ce qu'il y en a une autre ? (Si oui, reposer toutes les sous-questions du 1.1). Et redemander ensuite si encore une autre difficulté avec toutes les sous-questions jusqu'à que le coach dise qu'il n'y a pas d'autres difficultés.
2. Solutions
2.1 Solutions difficulté 1 : La difficulté la plus importante pour vous dans vos suivis avec des clients souffrant de TP était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ?
Solutions mises en place ou imaginées pour pallier cette difficulté
2.2 Solutions autres difficultés : Une deuxième difficulté pour vous était … Quelles solutions avez-vous mises en place ou imaginées pour pallier cette dernière ? (Reposer toutes les sous-questions du 2.1). Et faire ensuite la même chose pour les autres difficultés.
3. IPS
Programme IPS adapté pour les suivis de clients souffrant de TP selon vous ?
Adaptations du programme IPS possibles pour les suivis de clients souffrant de TP ?

Interview topic guide translated to English – Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: Version 1

Part 1: Difficult intervention with PD clients

1. Difficulties
1.1 Difficulty 1: Can you tell us what the most significant difficulty is in your experience with PD clients?
Coach's difficulty and concrete example
Origins and explanations of the difficulty
Moment when the difficulty arises in the intervention
Frequency and duration of the difficulty
1.2 Other present difficulties: You have identified this difficulty in the intervention, is there another one? (If yes, repeat all sub-questions from 1.1). Then ask if there is another difficulty with all the sub-questions until the coach says there are no further difficulties.
2. Solutions
2.1 Solutions for difficulty 1: The most important difficulty for you in experience with PD clients was... What solutions have you implemented or imagined to address this?
Implemented or imagined solutions to address this difficulty
2.2 Solutions for other difficulties: A second difficulty for you was... What solutions have you implemented or imagined to address this? (Repeat all sub-questions from 2.1). Then do the same for other difficulties.
3. IPS
Is the IPS programme adapted to PD clients in your opinion?
Possible adaptations of the IPS programme for PD clients?

Part 2: Difficult intervention with SMI clients

1. Difficulties
1.1 Difficulty 1: Can you tell us what the most significant difficulty is in your experience with SMI clients?
Coach's difficulty and concrete example
Origins and explanations of the difficulty
Moment when the difficulty arises in the intervention
Frequency and duration of the difficulty
1.2 Other present difficulties: You have identified this difficulty in the intervention, is there another one? (If yes, repeat all sub-questions from 1.1). Then ask if there is another difficulty with all the sub-questions until the coach says there are no further difficulties.
2. Solutions
2.1 Solutions for difficulty 1: The most important difficulty for you in experience with SMI clients was... What solutions have you implemented or imagined to address this?
Implemented or imagined solutions to address this difficulty
2.2 Solutions for other difficulties: A second difficulty for you was... What solutions have you implemented or imagined to address this? (Repeat all sub-questions from 2.1). Then do the same for other difficulties.
3. IPS
Is the IPS programme adapted to SMI clients in your opinion?
Possible adaptations of the SMI programme for PD clients?

Interview topic guide translated to English – Supported employment coaches' difficulties and facilitators with clients diagnosed with personality versus other disorders: Version 2

Part 1: Difficult intervention with SMI clients

1. Difficulties
1.1 Difficulty 1: Can you tell us what the most significant difficulty is in your experience with SMI clients?
Coach's difficulty and concrete example
Origins and explanations of the difficulty
Moment when the difficulty arises in the intervention
Frequency and duration of the difficulty
1.2 Other present difficulties: You have identified this difficulty in the intervention, is there another one? (If yes, repeat all sub-questions from 1.1). Then ask if there is another difficulty with all the sub-questions until the coach says there are no further difficulties.
2. Solutions
2.1 Solutions for difficulty 1: The most important difficulty for you in experience with SMI clients was... What solutions have you implemented or imagined to address this?
Implemented or imagined solutions to address this difficulty
2.2 Solutions for other difficulties: A second difficulty for you was... What solutions have you implemented or imagined to address this? (Repeat all sub-questions from 2.1). Then do the same for other difficulties.
3. IPS
Is the IPS programme adapted to SMI clients in your opinion?
Possible adaptations of the SMI programme for PD clients?

Part 2: Difficult intervention with PD clients

1. Difficulties
1.1 Difficulty 1: Can you tell us what the most significant difficulty is in your experience with PD clients?
Coach's difficulty and concrete example
Origins and explanations of the difficulty
Moment when the difficulty arises in the intervention
Frequency and duration of the difficulty
1.2 Other present difficulties: You have identified this difficulty in the intervention, is there another one? (If yes, repeat all sub-questions from 1.1). Then ask if there is another difficulty with all the sub-questions until the coach says there are no further difficulties.
2. Solutions
2.1 Solutions for difficulty 1: The most important difficulty for you in experience with PD clients was... What solutions have you implemented or imagined to address this?
Implemented or imagined solutions to address this difficulty
2.2 Solutions for other difficulties: A second difficulty for you was... What solutions have you implemented or imagined to address this? (Repeat all sub-questions from 2.1). Then do the same for other difficulties.
3. IPS
Is the IPS programme adapted to PD clients in your opinion?
Possible adaptations of the IPS programme for PD clients?

Focus group original topic guide in French – Good Psychiatric Management for borderline personality disorder: Implementation in a supported employment team

Que pensez-vous de l'intégration du GPM dans le suivi IPS des personnes présentant un TPB ?

Voyez-vous un intérêt à utiliser le GPM dans votre pratique ? Pourquoi ?

Quels en seraient les bénéfices pour vous et vos clients ? Quelles attentes nourrissez-vous à l'égard d'un programme comme celui-là ?

Quelles seraient les limites, voire les inconvénients à utiliser le GPM dans IPS ?

Pensez-vous que le GPM et IPS sont compatibles ou incompatibles ? Sur quels principes ? Pourquoi ?

Imaginez adopter le GPM, qu'est-ce que cela pourrait changer dans vos tâches, votre rôle et vos compétences concernant votre travail ? Quels seraient les obstacles qui pourraient restreindre, voire empêcher votre pratique du GPM ?

Quels seraient les éléments nécessaires pour une bonne implémentation du GPM dans IPS ?

Focus group topic guide translated to English – Good Psychiatric Management for borderline personality disorder: Implementation in a supported employment team

What do you think about integrating GPM into IPS intervention for individuals with BPD?

Do you see any value in using GPM in your practice? Why?

What would be the benefits for you and your clients? What expectations do you have regarding a programme like this? What are the potential limitations or disadvantages of using GPM in IPS?

Do you think GPM and IPS are compatible or incompatible? Based on what principles? Why?

Imagine adopting GPM, how might this change your tasks, role, and skills regarding your work? What obstacles could restrict or prevent your use of GPM?

What elements are necessary for a successful implementation of GPM in IPS?

Interview original topic guide in French – Good Psychiatric Management for borderline personality disorder: Implementation in a supported employment team

Vous avez participé à la formation au Good Psychiatric Management pour le trouble de la personnalité borderline. Nous allons effectuer un entretien afin de recueillir votre opinion sur le GPM dans le contexte d'IPS, et voir comment vous l'avez mis en pratique. Cet entretien va être enregistré.

Adoption

La formation au GPM vous a-t-elle conduit à changer certains aspects de votre pratique ? Lesquels ?

Comment cela s'est-il passé ?

Comment vos pratiques ont-elles évolué ?

Avec quels clients ?

Quels points posent problèmes dans votre mise en pratique du GPM ?

Acceptabilité

D'après vous, quels sont les bénéfices et les limites du GPM pour votre pratique d'IPS ?

Jugez-vous les changements décrits de votre pratique de manière plutôt positive ou négative ? Lesquels considérez-vous comme positifs ? Lesquels comme négatifs ?

Est-ce que cela a renforcé vos compétences ? Vous sentez-vous mieux armé pour faire face aux difficultés ? Avec quels types de clients ?

Pourriez-vous me donner l'exemple d'un candidat pour qui avoir adopté le GPM a été bénéfique ? Quel a été ce bénéfice ? Qu'est-ce que le GPM vous apporté qui n'aurait pas eu lieu dans un suivi IPS classique ?

Avez-vous un exemple de cas ou le GPM ne vous a pas aidé ? Que s'est-il passé ? Quelles étaient vos attentes et comment les choses se sont-elles déroulées réellement ?

Fidélité

Vous trouvez sur cette fiche les principes du GPM. **En revoyant ces principes, pouvez-vous m'indiquer ceux que vous avez intégré dans votre pratique et ceux qui n'en font pas partie ?**

D'après vous, quelles raisons vous on conduit à privilégier certains principes et pas les autres ?

Faisabilité

A quel point jugez-vous que le GPM soit compatible avec votre pratique IPS et adapté à vos tâches ? Qu'est-ce qui vous paraît le mieux s'adapter à votre pratique d'IPS et vos tâches dans ce cadre ?

A quel point jugez-vous que le GPM soit adapté à vos candidats ? Qu'est-ce qui vous paraît le mieux s'adapter à eux ?

Est-ce que certains aspects du GPM vous paraissent peu adaptés aux candidats ?

Auriez-vous besoin de formations et/ou de supervisions supplémentaires pour la bonne mise en pratique du GPM ?

Pertinence

Vous pouvez voir sur cette feuille les principes du GPM et d'IPS. **Trouvez-vous que les principes d'IPS et du GPM se complètent ? Se contrecarrent ? Lesquels ?**

Est-ce que votre expérience personnelle vous parait généralisable à plus grande échelle ?

Seriez-vous d'avis qu'il faille systématiser l'intégration GPM dans le cadre d'IPS ? Comment et pourquoi ?

Interview topic guide translated to English – Good Psychiatric Management for borderline personality disorder: Implementation in a supported employment team

You participated in the training on Good Psychiatric Management for borderline personality disorder. We will conduct an interview to gather your opinion on GPM in the context of IPS and see how you have implemented it. This interview will be recorded.

Adoption

Did the GPM training lead you to change certain aspects of your practice? Which ones?

How did this happen?

How has your practice evolved?

With which clients?

What challenges do you encounter in implementing GPM?

Acceptability

In your opinion, what are the benefits and limitations of GPM for your IPS practice?

Do you judge the described changes in your practice rather positively or negatively? Which ones do you consider positive? Which ones as negative?

Has this strengthened your skills? Do you feel better equipped to deal with difficulties? With which types of clients?

Could you give me an example of a client for whom adopting GPM has been beneficial? What was this benefit? What does GPM provide you that would not have occurred in a typical IPS intervention?

Do you have an example of a case where GPM did not help you? What happened? What were your expectations and how did things actually unfold?

Fidelity

You will find the principles of GPM on this sheet. **By reviewing these principles, can you tell me which ones you have integrated into your practice and which ones are not part of it?**

In your opinion, what reasons led you to prioritise certain principles and not others?

Feasibility

How compatible do you think GPM is with your IPS practice and suitable for your tasks? What seems to best fit your IPS practice and tasks within this framework?

How suitable do you think GPM is for your clients? What seems to best fit them?

Do certain aspects of GPM seem unsuitable for clients?

Would you need additional training and/or supervision for the proper implementation of GPM?

Appropriateness

You can see the principles of GPM and IPS on this sheet. **Do you think IPS and GPM principles complement each other? Contradict each other? Which ones?**

Does your personal experience seem generalisable on a larger scale?

Would you be of the opinion that GPM integration should be systematised within the framework of IPS? How and why?

Interview original topic guide in French – Good Psychiatric Management for borderline personality disorder in supported employment: Clients' experiences

Bonjour, merci d'avoir accepté de participer à cet entretien dont l'objectif est de connaître votre opinion sur votre suivi de soutien à l'emploi dans le cadre de RESSORT. L'entretien est enregistré, il sera retranscrit de façon anonyme, votre nom ainsi que tous ceux que vous mentionnerez seront remplacés et aucune trace de votre identité n'y apparaîtra.

Nous allons vous poser des questions sur l'histoire de votre suivi, la relation avec votre job coach, puis nous parlerons de vos difficultés, de leur impact sur votre réinsertion professionnelle et ce qu'a pu vous apporter l'intervention, avant de clore sur quelques mots concernant votre satisfaction.

Récit général et moments clés du suivi

***Question directric*e : RESSORT**
Vous a-t-on parlé de façon générale de RESSORT, son but général et qu'en avez-vous retenu ?

Sous-questions plus spécifiques (si besoin)
Comment RESSORT vous a-t-il été présenté, son but, les moyens pour y arriver, sa durée ?

Questions directrices : votre suivi
Pourriez-vous décrire brièvement l'histoire de votre suivi à RESSORT ?
Y a-t-il eu d'après vous des moments clés dans ce suivi, si oui lesquels et pourquoi ?

Sous-questions plus spécifiques (si besoin)
Comment avez-vous fixé les objectifs du suivi ? Étaient-ils clairs et partagés avec votre job coach ?
Quelles méthodes ont été mises en place pour les atteindre ?
Comment avez-vous mesuré les résultats ?
Y a-t-il eu des bilans réguliers ?

Alliance thérapeutique

Question directrice : le job coach
Parlons de votre job coach. Comment le·la décririez-vous ?

Sous-questions plus spécifiques
D'après vous, quels sont ses qualités et ses défauts en tant que professionnel·le ?

Qualités d'empathie, d'authenticité, de bienveillance, d'écoute, de compréhension, de disponibilité et de non-jugement ?
Votre job coach tient-il·elle compte de votre état dans son attitude face à vous ?

Question directrice : la relation
Comment décririez-vous la relation qui s'est nouée entre vous ?

Sous-questions plus spécifiques
Quels en sont les points positifs et négatifs ?
Comment vous sentez-vous avec votre job coach ?
Vous sentez-vous libre de vous exprimer, de ressentir et de penser ?

Question directrice : engagement et collaboration dans le suivi
Avez-vous l'impression de collaborer ensemble et que vous êtes les deux engagés dans le suivi, ou à l'inverse, que l'un de vous est plus engagé que l'autre ?

Sous-questions plus spécifiques
Quelle part de responsabilité pensez-vous avoir dans votre prise en charge ?
Êtes-vous assidu·e aux entretiens ? Effectuez-vous les tâches qui vous sont demandées d'une séance à l'autre ? Qui décide de ces tâches ? Venez-vous aux entretiens fixés avec votre job coach ?
Votre job coach tient-il ses engagements ? Reconnaît-il ses erreurs ?

Question directrice : le réseau de soins
Comment ressentez-vous la collaboration entre les différents membres de votre réseau de soin ?

Sous-questions spécifiques
Les différents acteurs communiquent-ils entre eux ?
Recevez-vous de leur part des messages différents, si oui lesquels ? Abordent-ils des sujets différents avec vous ?
Recevez-vous des messages similaires, si oui lesquels ?
Les informations qu'ils vous transmettent vous paraissent-elles cohérentes ou contradictoires ?
Avez-vous l'impression que les membres de votre réseau de soins sont solidaires, qu'ils partagent le même but ? Ce but est-il le même que le vôtre ?

Efficacité

Questions directrices : trouble, ses manifestations et ses effets sur la réinsertion professionnelle avant le début de suivi
Vous souffrez d'un trouble de la personnalité borderline. Que saviez-vous de ce trouble, de ses effets sur la réinsertion professionnelle au moment de débuter le suivi de soutien à l'emploi ?

Sous-questions spécifiques
Saviez-vous quoi faire en cas de crise ?
Aviez-vous un plan de crise conjoint ?
Appliquiez-vous ces méthodes quand nécessaire ?

Questions directrices : trouble, ses manifestations et ses effets sur la réinsertion professionnelle après quelques mois de suivi
Que savez-vous aujourd'hui de ce trouble, de ses effets sur la réinsertion professionnelle ?

Sous-questions spécifiques
Savez-vous quoi faire en cas de crise ?
Avez-vous un plan de crise conjoint ?
Appliquez-vous ces méthodes quand nécessaire ?

Question directrice : effet de l'intervention et éléments d'efficacité
Décrivez les changements qui ont eu lieu dans votre situation au cours de votre suivi de soutien à l'emploi.

Sous-questions spécifiques
Quels sont ceux que vous jugez comme positifs et négatifs ?
En quoi l'intervention vous a-t-elle aidé ? Pas aidé ?
Qu'est-ce que l'intervention vous a apporté ?
Quels éléments de l'intervention vous ont paru utiles ? Lesquels vous ont paru inutiles ou néfastes ?
A quel point cette intervention a-t-elle aidé à résoudre le problème spécifique qui vous a conduit à rejoindre le programme ?
Pouvez-vous vous concentrer sur ce qui vous préoccupe vraiment dans le suivi IPS ?
Êtes-vous maintenant capable de gérer plus efficacement vos problèmes ?
Arrivez-vous à apprendre des situations problématiques antérieures pour éviter de les reproduire ?
Avez-vous retrouvé un rôle professionnel ? Si oui, vous y identifiez-vous ?

Satisfaction

Questions directrices
Qu'est-ce qui vous a satisfait et déplu ou déçu dans cette intervention ?
Qu'est-ce qui a répondu à vos besoins et qu'est-ce qui manquerait pour y répondre ?

Sous-question spécifique
Recommenderiez-vous cette intervention à un ou une ami.e qui aurait le même trouble que vous et qui serait intéressé.e à la suivre ?

Que garderiez-vous et quels changements souhaiteriez-vous dans votre prise en charge si vous pouviez repartir à zéro ?
Ce programme vous donne-t-il de l'espoir ?

Interview topic guide translated to English – Good Psychiatric Management for borderline personality disorder in supported employment: Clients' experiences

Hello, thank you for agreeing to participate in this interview aimed at understanding your opinion on your supported employment intervention within the framework of RESSORT. The interview is recorded, it will be transcribed anonymously, your name as well as all those you mention will be replaced, and no trace of your identity will appear.

We will ask you questions about the history of your path in supported employment, the relationship with your job coach, then we will talk about your difficulties, their impact on your vocational reintegration, and what the intervention may have brought you, before closing with a few words regarding your satisfaction.

General narrative and key moments of intervention

Main question: RESSORT
Have you been generally informed about RESSORT, its overall purpose, and what have you retained from it?

More specific sub-questions (if necessary)
How was RESSORT presented to you, its purpose, the means to achieve goals, its duration?

Main questions: Your follow-up
Could you briefly describe the history of your intervention at RESSORT?
In your opinion, were there key moments in this intervention, if yes, which ones and why?

More specific sub-questions (if necessary)
How did you set the intervention goals? Were they clear and shared with your job coach?
What methods were implemented to achieve them?
How did you measure the results?
Were there regular assessments?

Therapeutic alliance

Main question: The job coach
Let's talk about your job coach. How would you describe him/her?

More specific sub-questions

In your opinion, what are his/her qualities and shortcomings as a professional? Qualities of empathy, authenticity, kindness, listening, understanding, availability, and non-judgment?
Does your job coach take your state into account in his/her attitude towards you?

Main question: The relationship
How would you describe the relationship that has developed between both of you?
More specific sub-questions
What are the positive and negative aspects?
How do you feel with your job coach?
Do you feel free to express yourself, to feel, and to think?

Main question: Engagement and collaboration in intervention
Do you feel like you are collaborating and that both of you are engaged in the intervention, or conversely, that one of you is more engaged than the other?

More specific sub-questions
How much responsibility do you think you have in your care?
Are you diligent in appointments? Do you carry out the tasks requested from one session to another? Who decides on these tasks? Do you attend appointments set with your job coach?
Does your job coach keep his/her commitments? Does he/she acknowledge his/her mistakes?

Main question: Healthcare network
How do you feel about the collaboration between the various members of your healthcare network?

Specific sub-questions
Do the different actors communicate with each other?
Do you receive different messages from them, if so, what? Do they address different topics with you?
Do you receive similar messages, if so, what?
Do the messages they transmit to you seem consistent or contradictory?
Do you feel that the members of your healthcare network are supportive, that they share the same goal? Is this goal the same as yours?

Effectiveness

Main questions: Disorder, its manifestations, and its effects on vocational reintegration before the start of the intervention

You suffer from borderline personality disorder. What did you know about this disorder, its effects on vocational reintegration when starting the supported employment intervention?

Specific sub-questions
Did you know what to do in case of crisis?
Did you have a joint crisis plan?
Did you apply these methods when necessary?

Main questions: Disorder, its manifestations, and its effects on vocational reintegration after a few months of intervention
What do you know today about this disorder, its effects on vocational reintegration?

Specific sub-questions
Do you know what to do in case of crisis?
Do you have a joint crisis plan?
Do you apply these methods when necessary?

Main question: Effect of the intervention and effectiveness elements
Describe the changes that have occurred in your situation during your supported employment intervention.

Specific sub-questions
Which ones do you consider positive and negative?
How did the intervention help you? Not help you?
What has the intervention brought you?
Which elements of the intervention seemed useful to you? Which ones seemed useless or harmful?
To what extent did this intervention help resolve the specific problem that led you to join the programme?
Can you focus on what really concerns you in IPS intervention?
Are you now able to manage your problems more effectively?
Do you learn from previous problematic situations to avoid reproducing them?
Have you regained a professional role? If so, do you identify with it?

Satisfaction

Main questions
What satisfied and dissatisfied or disappointed you in this intervention?
What met your needs and what would be missing to meet them?

Specific sub-question

Would you recommend this intervention to a friend who has the same disorder as you and who would be interested in taking part in it?
What would you keep and what changes would you like in your care if you could start over?
Does this programme give you hope?

Instructions:

Borderline Symptom List (BSL-23)

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you think you might have felt. Please answer honestly. All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average. Please be sure to answer each question.

		Not at all	A little	Rather	Much	Very strong
1	It was hard for me to concentrate	**0**	**1**	**2**	**3**	**4**
2	I felt helpless	**0**	**1**	**2**	**3**	**4**
3	I was absent-minded and unable to remember what I was actually doing	**0**	**1**	**2**	**3**	**4**
4	I felt disgust	**0**	**1**	**2**	**3**	**4**
5	I thought of hurting myself	**0**	**1**	**2**	**3**	**4**
6	I didn't trust other people	**0**	**1**	**2**	**3**	**4**
7	I didn't believe in my right to live	**0**	**1**	**2**	**3**	**4**
8	I was lonely	**0**	**1**	**2**	**3**	**4**
9	I experienced stressful inner tension	**0**	**1**	**2**	**3**	**4**
10	I had images that I was very much afraid of	**0**	**1**	**2**	**3**	**4**
11	I hated myself	**0**	**1**	**2**	**3**	**4**
12	I wanted to punish myself	**0**	**1**	**2**	**3**	**4**
13	I suffered from shame	**0**	**1**	**2**	**3**	**4**
14	My mood rapidly cycled in terms of anxiety, anger, and depression	**0**	**1**	**2**	**3**	**4**
15	I suffered from voices and noises from inside and/or outside my head	**0**	**1**	**2**	**3**	**4**
16	Criticism had a devastating effect on me	**0**	**1**	**2**	**3**	**4**
17	I felt vulnerable	**0**	**1**	**2**	**3**	**4**
18	The idea of death had a certain fascination for me	**0**	**1**	**2**	**3**	**4**
19	Everything seemed senseless to me	**0**	**1**	**2**	**3**	**4**
20	I was afraid of losing control	**0**	**1**	**2**	**3**	**4**
21	I felt disgusted by myself	**0**	**1**	**2**	**3**	**4**
22	I felt as if I was far away from myself	**0**	**1**	**2**	**3**	**4**
23	I felt worthless	**0**	**1**	**2**	**3**	**4**

Liste des symptômes borderline (French version of the BSL-23)

Dans les tableaux ci-dessous, vous trouverez une série de difficultés et de problèmes qui pourraient vous correspondre. Veuillez parcourir le questionnaire et évaluer l'intensité de la souffrance associée à chacun de ces problèmes durant la semaine qui vient de s'écouler. Si vous ne ressentez pas d'émotions actuellement, veuillez répondre en imaginant les « émotions que vous auriez pu avoir ». Merci de répondre avec sincérité.
Toutes les questions se réfèrent à la semaine qui vient de s'écouler. Si vous avez traversé différents états à différents moments, répondez par une estimation de l'état moyen durant la semaine.
Assurez-vous de répondre à toutes les questions.

	Durant la semaine passée…	pas du tout	un peu	plutôt	beaucoup	tout le temps
1	Il m'était difficile de me concentrer	0	1	2	3	4
2	J'étais désespéré(e)	0	1	2	3	4
3	J'avais l'esprit ailleurs et j'étais incapable de me rappeler ce que j'étais en train de faire	0	1	2	3	4
4	Je me suis senti(e) dégouté(e)	0	1	2	3	4
5	J'ai pensé à me faire du mal	0	1	2	3	4
6	Je n'avais pas confiance aux autres	0	1	2	3	4
7	Je ne croyais pas en mon droit de vivre	0	1	2	3	4
8	J'étais seul(e)	0	1	2	3	4
9	J'ai vécu une tension interne stressante	0	1	2	3	4
10	J'avais des images qui me faisaient peur	0	1	2	3	4
11	Je me détestais	0	1	2	3	4
12	Je voulais me punir	0	1	2	3	4
13	J'ai éprouvé de la honte	0	1	2	3	4
14	Mon humeur changeait rapidement passant de l'anxiété, à la colère et à la tristesse	0	1	2	3	4
15	J'ai entendu des voix et des bruits provenant de l'intérieur ou de l'extérieur de ma tête	0	1	2	3	4
16	Les critiques d'autrui ont eu un effet dévastateur sur moi	0	1	2	3	4
17	Je me suis senti(e) vulnérable	0	1	2	3	4
18	L'idée de la mort m'a fasciné(e)	0	1	2	3	4
19	Tout me paraissait vide de sens	0	1	2	3	4
20	J'avais peur de perdre le contrôle	0	1	2	3	4
21	Je me suis senti(e) dégoûté(e) de moi-même	0	1	2	3	4
22	Je me suis senti(e) comme très éloigné(e) de moi-même	0	1	2	3	4
23	Je me suis senti(e) sans valeur	0	1	2	3	4

Satisfaction with Therapy and Therapist Scale-Revised (STTS-R)

Please circle the number that best describes your opinion of your satisfaction with the therapy and therapists in the group CBT treatment attended/completed by you recently.

Strongly agree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

1. I am satisfied with the quality of the therapy I received	1	2	3	4	5
2. The therapist listened to what I was trying to get across	1	2	3	4	5
3. My needs were met by the program	1	2	3	4	5
4. The therapist provided an adequate explanation regarding my therapy	1	2	3	4	5
5. I would recommend the program to a friend	1	2	3	4	5
6. The therapist was not negative or critical towards me	1	2	3	4	5
7. I would return to the clinic if I needed help	1	2	3	4	5
8. The therapist was friendly and warm towards me	1	2	3	4	5
9. I am now able to deal more effectively with my problems	1	2	3	4	5
10. I felt free to express myself	1	2	3	4	5
11. I was able to focus on what was of real concern to me	1	2	3	4	5
12. The therapist seemed to understand what I was thinking and feeling	1	2	3	4	5

Outcome Variable:		
13. How much did this treatment help with the specific problem that led you to therapy?	Made things a lot better	1
	Made things somewhat better	2
	Made no difference	3
	Made things somewhat worse	4
	Made things a lot worse	5

Échelle de satisfaction de l'intervention et de l'intervenant (STTS-R translated to French)

Traduction et adaptation par notre équipe pour cette étude.

Veuillez entourer le chiffre qui décrit le mieux votre opinion au sujet du programme IPS que vous suivez ou avez suivi récemment, et de votre conseiller en insertion qui sera nommé ici job coach.

Fortement en désaccord	En désaccord	Neutre	D'accord	Fortement d'accord
1	2	3	4	5
1. Je suis satisfait de la qualité de mon suivi IPS	1	2	3	4	5
2. Le job coach a écouté ce que j'essayais de lui faire comprendre	1	2	3	4	5
3. Mes besoins ont été satisfaits par le programme	1	2	3	4	5
4. Le job coach a fourni une explication adéquate sur mon suivi IPS	1	2	3	4	5
5. Je recommanderais IPS à un ami	1	2	3	4	5
6. Le job coach n'était pas négatif ou critique envers moi	1	2	3	4	5
7. Je retournerais dans le programme si j'avais besoin d'aide dans le futur	1	2	3	4	5
8. Le job coach était aimable et chaleureux envers moi	1	2	3	4	5
9. Je suis maintenant capable de gérer plus efficacement mes problèmes	1	2	3	4	5
10. Je me suis senti libre de m'exprimer	1	2	3	4	5
11. J'ai pu me concentrer sur ce qui me préoccupait vraiment	1	2	3	4	5
12. Le job coach semblait comprendre ce que je pensais et ressentais	1	2	3	4	5
13. A quel point cette intervention a-t-elle aidé à résoudre le problème spécifique qui vous a conduit à rejoindre le programme ?	Les choses se sont beaucoup améliorées				1
	Les choses se sont un peu améliorées				2
	Il n'y a eu aucune différence				3
	Les choses ont un peu empiré				4
	Les choses ont beaucoup empiré				5

Readiness for Work Questionnaire (WoRQ)

TABLE 1. Work Readiness Questionnaire (WoRQ v4.0). Instructions: This instrument defines work as any useful activity that could merit pay, and does not include work that requires an unusual level of supervision or rehabilitation work. Activities of daily living can include using public transportation and meal preparation, in addition to basic self-care. The judgment on work readiness is independent of whether a job is available to the patient. The 7 items below are provided as a guide for answering the final question in the box. Please read each statement below and select a response based on all sources of information available. The final question is a global judgment and not the sum of the previous items.

Item	Description	Strongly agree 1	Agree 2	Disagree 3	Strongly disagree 4
Item 1	The patient generally adheres to a treatment plan, including medication.				
Item 2	The patient is able to carry out activities of daily living.				
Item 3	The patient is able to consistently keep appointments and schedules with only minimal assistance.				
Item 4	The patient would have adequate impulse control when interacting with authority figures, peers or coworkers, and potential customers.				
Item 5	The patient's behavior would not make others uncomfortable in a work situation.				
Item 6	The patient's appearance would not make others uncomfortable in a work situation.				
Item 7	The patient's current symptoms would not interfere with the ability to hold a job.				
	Based on your clinical judgment, is this patient ready for work?	Yes			No

Disposition à travailler (WoRQ translated to French)

Traduction par notre équipe pour cette étude.

Cet instrument définit le travail comme toute activité utile qui mérite une rémunération dans la première économie. Les emplois protégés et à visée de réadaptation professionnelle ne sont pas inclus sous ce terme. Les activités de la vie quotidienne peuvent inclure l'utilisation des transports publics et la préparation des repas, en plus des soins personnels de base. Le jugement de la disposition à travailler est indépendant de la question de savoir si un emploi est disponible pour le client.

Les 7 items ci-dessous sont fournis comme guide pour répondre à la dernière question de l'encadré. Veuillez lire chaque affirmation ci-dessous et sélectionner une réponse en fonction de toutes les sources d'information disponibles. La dernière question est un jugement global et non la somme des items précédents.

Item	***Description***	Tout à fait d'accord **1**	D'accord **2**	Pas d'accord **3**	Pas du tout d'accord **4**
Item 1	Le client adhère généralement à un plan de traitement, y compris les médicaments.	☐	☐	☐	☐
Item 2	Le client est capable d'effectuer les activités de la vie quotidienne.	☐	☐	☐	☐
Item 3	Le client est capable de respecter systématiquement ses rendez-vous et son emploi du temps avec seulement un minimum d'aide.	☐	☐	☐	☐
Item 4	Le client aurait un contrôle adéquat de ses impulsions s'il interagissait avec des figures d'autorité, des pairs ou collègues de travail, et des clients potentiels.	☐	☐	☐	☐
Item 5	Le comportement du client ne mettrait pas les autres mal à l'aise dans une situation de travail.	☐	☐	☐	☐
Item 6	L'apparence du client ne mettrait pas les autres mal à l'aise dans une situation de travail.	☐	☐	☐	☐
Item 7	Les symptômes actuels du client n'interféreraient pas avec sa capacité à occuper un poste.	☐	☐	☐	☐
	D'après votre jugement clinique, ce client est-il prêt à travailler ?		☐ oui	☐ non	