Good-Enough Therapy: A Review of the Empirical Basis of Good Psychiatric Management

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In this review, the question of whether good psychiatric management (GPM) has a sufficient, or good-enough, evidence base is examined from two complementary perspectives. First, the author reviews research that has investigated whether GPM reduces symptoms of borderline personality disorder. Analyses at the group and individual levels have indicated that symptoms may decrease among patients receiving GPM. Second, the author reviews research that has investigated the processes through which change occurs in GPM. Studies that have shown process changes toward emotional balance, interpersonally effective functioning, and a more coherent and reality-based autobiographical narrative are discussed. To fully answer the question of whether GPM is good enough, more controlled trials are needed to demonstrate effectiveness, mechanisms of change, and broad implementation in culturally diverse populations.

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Good psychiatric management (GPM) has been described as a set of fundamental intervention principles, woven together with clinical wisdom (1, 2), to treat severe personality pathology. These intervention principles are straightforward, were designed to be helpful to the clinician and the patient, and were developed to address the limited availability of experts to provide treatment for borderline personality disorder (3). In addition to specialized psychotherapies for the treatment of borderline personality disorder and other forms of severe personality pathology, easy-to-implement interventions that are based on a theory of interpersonal hypersensitivity (4) may be useful. The notion of helpfulness, or pragmatic effectiveness, in assisting the patient to decrease symptoms and improve psychosocial functioning is central to GPM.

The research question posed in this review is as follows: Does GPM have a good-enough empirical basis? This narrative review describes the body of knowledge on GPM's outcomes, as well as on its processes and mechanisms of change. Drawing from published studies available at the time of submission, this review synthesizes the author's knowledge of the field and the findings of the many studies in which he was involved and concludes with a set of recommendations for future research. Although some studies may have been missed, this limited review provides a coherent perspective on the research question.

OUTCOME: THE USEFULNESS OF GPM FOR HELPING PATIENTS TO "GET A LIFE"

A definition of "getting a life" for individuals with borderline personality disorder is needed. According to Gunderson and Links (2), achieving this goal means that an individual has less severe symptoms of borderline personality disorder—to the extent that if symptoms remain present, they do not interfere with psychosocial functioning. In addition, individuals need to be able to function on an interpersonal level, have several sufficiently nourishing interpersonal and intimate relationships, and be able to pursue a professional or academic activity that is in line with their goals. Taken together, this definition of getting a life combines symptom remission and recovery (5).

In Canada, McMain et al. (6, 7) compared dialectical behavior therapy (DBT) with general psychiatric management. The results showed that the mean number of suicidal episodes—the main outcome of this trial—decreased, from just below two at intake to just below 0.5 at the end of treatment (12 months), for both therapies. These effects were

HIGHLIGHTS

- Results to date indicate baseline-to-posttreatment symptom changes among patients with severe personality pathology treated with good psychiatric management (GPM).
- Emotional changes, sociocognitive effectiveness, and narrative integration may be central processes through which patients experience improvements when treated with GPM.
- Assessing the impacts of out-of-session factors will enrich the understanding of how GPM works.

comparable for both treatment conditions at the 12-month follow-up (7), and consistent results were found for the secondary outcomes, with no differences between the two treatment conditions. At the group level, no difference was found in the effectiveness of DBT versus GPM. In an attempt to understand which therapy was the most suitable for which patient profiles, Keefe and colleagues (8) reanalyzed the McMain et al. (6, 7) data set by using the Personalized Advantage Index. Six moderator variables were selected. The best treatment was identified for each variable, with each one representing a specific patient feature. The ensuing results indicated that GPM was particularly promising for patients experiencing general symptoms and impulsive behavior, but less so for patients with depression and a history of emotional abuse, a dependent personality style, or social maladjustment. The results also indicated that although the effectiveness of GPM was comparable to that of DBT on the group level, GPM's effectiveness may depend on the specific clinical features of an individual patient. These results have important implications for triage and treatment selection.

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In line with the dissemination of good-enough psychiatric practice for borderline personality disorder, a series of GPM studies was carried out in Switzerland. Two randomized controlled trials (9, 10) compared a brief version of GPM with a personalized treatment selected on the basis of case formulation. The initial rationale for selecting GPM for use in these outcome trials was to use a guideline-based approach to study the impact of personalized treatment on processes and outcomes in psychotherapy. The brief (4 months) version of GPM used in the trials focused on discussing with the patient the diagnosis of borderline personality disorder and treating core problems in accordance with the interpersonal hypersensitivity model (11). The results indicated that for general problems (e.g., those related to mood, anxiety, and anger), as well as for interpersonal problems and borderline personality disorder symptoms, the baseline-to-posttreatment effects across 4 months of either treatment approach were systematically large, whereas the between-group comparisons varied between medium and small effects, depending on the outcome measure. Importantly, no between-group effects for the change in borderline personality disorder symptoms were found, which may be interpreted as GPM being good enough for reducing borderline personality disorder symptoms but not necessarily for reducing general symptoms. Therapist adherence to GPM principles was generally acceptable, as measured by the General Psychiatric Management Adherence Scale (12), and predicted between 16% and 23% of the outcome variance (13). Grandjean et al. (14) used a machine-learning approach to attempt to profile patients from both trials (9, 10) to learn which patient characteristics benefited the most from the brief GPM intervention. They found that younger patients with severe borderline personality disorder symptoms and little social maladjustment benefited the most from brief GPM. Again, these conclusions are relevant for triage and for appropriate treatment selection for patients with various characteristics.

These studies indicate that patients with a severe form of borderline personality disorder who received GPM seemed to benefit from the treatment (15). This finding seemed true for a specific subgroup of individuals, namely, those with general and impulsive symptoms as well as borderline personality disorder symptoms. Patients with more problems with psychosocial adjustment may need more intensive treatment in order to get a life.

MECHANISMS OF CHANGE: HOW GPM MAY HELP PATIENTS

Psychotherapy research has historically focused on the processes and mechanisms of change associated with specific treatments ([16]; see the discussion by Cuijpers and colleagues [17]). This research has only recently been extended to psychotherapies for personality pathology (18–21). Research methodology has improved to allow for rigorous and clinically meaningful testing of the mechanisms of change associated with the functional domains of personality pathology (22). The recent move toward the dimensional model of personality pathology has opened new avenues of conceptualization for process research (23).

A mechanism of change can be understood as a generic principle of change that is consistent with underlying theory and is responsible for the change observed during treatment (24, 25). Doss (26) differentiated therapist interventions (i.e., providing psychoeducation on interpersonal hypersensitivity, conducting chain analyses), patient in-session processes (i.e., a shift in affective response to the therapist's intervention, a new understanding of the interpersonal dynamics), and the generic mechanism of change for a patient (i.e., out-of-session skills to interrupt unhelpful interpersonal dynamics and to understand one's and others' emotional responses). To attempt to anchor this model within the functional domains of personality pathology and to personalize pathways of change in relation to features of an individual case, Kramer et al. (19) proposed an integrative model of understanding mechanisms of change in psychotherapies for personality pathology. Such an understanding, supported by empirical evidence, should help the clinician to identify processes to foster in session (or out of session) that produce good outcomes, to develop new intermediate treatment goals, and to help tighten the focus on the essential functional domains of the personality pathology of the individual receiving treatment. All these factors may eventually contribute to an increase in the effectiveness of treatments.

For GPM, three functional domains have been studied as potential mechanisms of change: reaching emotional

balance, moving from problematic social interactions to interpersonal effectiveness, and developing a coherent, reality-based narrative. These domains are discussed below.

From Emotional Dysregulation to Emotional Balance

Reaching emotional balance can be as challenging as it is rewarding for patients with a personality disorder. In a design that separated the performance of the outcome assessment from that of the process assessment, Kramer and colleagues (27) used mediation analysis to demonstrate that the decrease of in-session behavioral coping (e.g., use of impulsive behaviors to cope with stress) between sessions 1 and 5 explained the decrease in symptoms observed between sessions 5 and 10 of the treatment. That study assumed that the intensity of any emotion should be regulated, neglecting the conceptualization of emotion types. The latter conceptualization is more differentiated than that used by Kramer et al. and will ultimately contribute to understanding emotional balance. Berthoud et al. (28) compared types of in-session emotions experienced by patients receiving brief GPM treatment with the types experienced by patients receiving treatment in which an individualized case formulation (identified through plan analysis) was added to brief GPM. Among all patients studied, Berthoud et al. (28) found a general decrease in global distress (i.e., a nonspecific expression of distress, mixed with some anger and often intensive frustration and hopelessness) and an increase in all other emotion categories (e.g., specific types of anger, shame, hurt, and grief) over the course of the GPM treatment. These processes were related to the symptom decrease, and these results indicate that GPM may foster not only emotion regulation but also emotion transformation (i.e., the move toward the productive use of arising emotions as a meaning-making process).

To investigate whether change across brief GPM was associated with biological response patterns in the brain when specific emotions were activated, Kramer and colleagues (29) developed a paradigm to assess self-contempt among patients with borderline personality disorder. In that study, out-of-session emotion-evoking experiential assessment was combined with functional magnetic resonance imaging (fMRI) and stimuli from the emotion-evoking assessment (30, 31). Stimuli extracted from these emotion-evoking assessments were introduced as individualized stimuli during fMRI. Results from a baseline-to-posttreatment analysis showed that the blood-oxygen-level–dependent signal detected in fMRI, which reflects changes in brain blood flow and oxygenation in response to stimuli, increased in the putamen in response to the individualized stimuli (compared with negative standard stimuli) at posttreatment. This result may have indicated more intense treatment of the cognitive content related to the individualized stimuli at the end of treatment. Changes in neurofunctional response patterns in the bilateral precuneus associated with the individualized stimuli predicted the decrease of in-session, subjectively perceived emotional arousal of the patients, which in turn predicted the decrease in borderline personality disorder symptoms. This pattern of results suggests that emotional balance may come to pass through activation of individually relevant, self-contemptuous cognitive contents, which lessen across treatment in the context of decreased in-session emotional arousal.

From Problematic Social Interactions to Interpersonal Effectiveness

Social cognitions—individuals' thought processes regarding social interactions—are key for understanding borderline personality disorder (32). In a process analysis, Keller and colleagues (33) showed that GPM was associated with a decrease in thought biases, but these in-session changes in the spontaneous discourse of the patient were not related to symptom changes. Kramer and Golam (34) reanalyzed these data in terms of cognitive heuristics—goal-oriented socio-cognitive patterns—and showed that a particular combination of in-session cognitions—called the trust-culprit heuristic—was related to better therapeutic alliance over the course of treatment. The trust-culprit heuristic represented a combination of numerous cognitive errors in taking over responsibility for social interactions, including with the therapist: the more patients expressed biases in thinking in this specific way—although problematic in itself—the better the therapeutic alliance. This result may have important clinical implications for stimulating collaboration within therapy. Signer and colleagues (35) analyzed the social interaction itself as a predictor of change and showed consistently that the activation of a problematic social interaction positively predicted the change at the end of treatment, that is, a reduction of interpersonal problems. This effect was larger in the individualized treatment that was based on the case formulation methodology than it was in the standard GPM treatment. These results indicate that in-session activation of problematic social interaction patterns, in the context of effective treatment for borderline personality disorder, may be an important first step toward interpersonal effectiveness. By using the methodology of the core conflictual relationship theme to assess in-session social interaction patterns, Kramer and colleagues (36) analyzed the in-session pervasiveness (i.e., the level of generalization across interactions) of these social interaction patterns. These researchers showed that the level of generalization of the patient's response to internal conflict lessened over the course of GPM. Although these changes were not related to general symptoms (e.g., to problems in mood, anxiety, or anger), they predicted the decrease in borderline personality disorder symptoms at the end of treatment. Some evidence exists that changes in social interaction patterns contribute to a healthy pathway to change in borderline personality disorder symptoms more broadly.

From Inconsistency to Coherent, Reality-Based Narratives

The functional domain of incoherent, pseudo-psychotic, and dissociative clinical presentations is central for some forms of borderline personality disorder but has been neglected in

the literature. To investigate in-session processes, Kramer and colleagues (37) analyzed the coherence of emotion-based narrative change over the course of brief GPM by assuming that the early decrease of in-session, problematic emotion-narrative process markers predicted the later symptom decrease. The authors found a statistically significant decrease in general symptoms after session 5 of brief GPM. To my knowledge, this result indicates the first evidence that GPM may also work via the progressive development of a coherent, reality-based emotion narrative.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH ON GPM

This review aimed to address the question of whether good psychiatric management has a good-enough empirical basis. This question echoes John Gunderson's reference to D. W. Winnicott's "good-enough mother," meaning that specialized psychotherapies for borderline personality disorder may be supplemented by a more generalist, straightforward, and easy-to-implement approach to therapy. Such an approach may avoid doing harm and may be effective and sufficient for many patients with severe personality pathology, especially those with borderline personality disorder. In terms of outcomes, the evidence suggests that using GPM principles to treat patients may produce change in borderline personality disorder and general symptoms. To reach a firmer conclusion about GPM's efficacy in reducing these problems, randomized controlled trials comparing GPM with treatment as usual (or community-based treatments that are not specific to borderline personality disorder) are needed. Only with this formal demonstration of effect can GPM be considered an evidence-based treatment for borderline personality disorder or, more broadly, for severe personality disorders (38–40).

To understand how psychotherapy works, the processes and mechanisms of change, both in and out of sessions, require study. The initial evidence for in-session processes explaining the effects of GPM encompasses changes in coping, emotion transformation processes, sociocognitive processes (interpersonal heuristics, interpersonal patterns, social interactions), and changes in emotion-based narrative. To my knowledge, only one study (29) to date has tested, in a controlled environment, the out-of-session mechanisms of change associated with GPM. By using fMRI in an emotion-evoking task to assess change in self-contempt, this research has broken new ground in the understanding of the impact of a clinical intervention on the new skills and insights patients learn through psychotherapy.

Changes observed in psychotherapy take place within the context of a trusting therapeutic relationship, and patients with personality disorders in particular have difficulty with engaging in such a trusting relationship. Ruptures in the therapeutic alliance are the norm and represent opportunities for the patient (and the therapist) to learn about the patient's processes and cognitions, as well as about the therapist's possible limitations. The present review does not discuss the literature on therapeutic alliance in GPM for borderline personality disorder (10, 41, 42).

Last, the studies referred to in this review were conducted in high-resource countries, such as Canada and Switzerland. To help clarify the impact of GPM principles on clinical practice and the process of recovery, more diverse research is needed, in various real-world contexts, on the outcomes and mechanisms of change in GPM.

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