RUNNING HEAD: Empirical basis of Good Psychiatric Management

Good Psychiatric Management: Does it have a "good enough" empirical basis?

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Abstract

The question whether good psychiatric management (GPM) has a sufficient, or good enough, evidence base is examined from two complementary perspectives.

Firstly, the author reviews research on GPM that has investigated whether it reduces symptoms in borderline personality disorder. Both analyses on the group level and on the individual level indicate that symptoms may decrease, as patients undergo GPM. More controlled research is needed, in particular on demonstrating recovery, and more research is needed that is more culturally diverse, speaking to an effective and broad implementation of GPM principles.

Secondly, the author reviews research on GPM that has investigated processes through which change occurs. The author discusses studies that show process changes towards emotional balance, interpersonally effective functioning and a more coherent and reality-based auto-biographical narrative. To answer this question more fully, it is necessary to have more controlled trials demonstrating the diverse mechanisms of change in GPM.

Highlights

1. Preliminary results indicate pre-post symptom changes in patients with severe personality pathology when treated with GPM.

2. Emotional changes, socio-cognitive effectiveness and narrative integration may be central to explaining processes through which patients experience improvements when treated with GPM.

3. Assessing the impacts of out-of-session factors will complement the understanding of how GPM works.

Keywords: Good Psychiatric Management; Borderline Personality Disorder; Effectiveness; Process Research; Psychotherapy Research

Good Psychiatric Management: Does it have a "good enough" empirical basis?

Good or general psychiatric management (GPM) is a set of fundamental intervention principles, woven together with clinical wisdom proposed by John G. Gunderson and colleagues (1, 2) to treat severe personality pathology. These intervention principles are straightforward to understand and designed to be helpful to the clinician and to the patient and were developed to address the limited availability of experts to provide treatment in the domain of borderline personality disorder (3). In addition to specialized psychotherapies for the treatment of borderline personality disorder and other forms of severe personality pathology, it may be helpful to develop easy-to-implement interventions based on an interpersonal hypersensitivity theory (4). The notion of "helpfulness", or pragmatic effectiveness, in helping the patient to "get a life", is particularly central to GPM.

At this juncture, the question posed by this paper – whether the empirical basis of GPM is "good enough" – is justified. The present paper will present a narrative review on the knowledge on outcome of GPM, as well as on processes and mechanisms of change. It will conclude with a set of recommendations to researchers for future study. The review will draw on published studies available at the time of submission. Given the author of the present review was involved in many of these studies, and/or has knowledge of the field, the present review synthesizes this body of work. While this may yield in a limited overview by missing some specific studies, it provides a coherent perspective on the research question to be addressed.

Outcome: is GPM helpful to get a life?

In order to answer this question, a definition of "getting a life" for individuals with borderline personality disorder is needed. According to Gunderson and Links (2), it involves for the individual to present with lowered symptoms of borderline personality disorder – to an extent that they, if still present, do not interfere with psychosocial functioning. In addition,

individuals need to be able to function on an interpersonal level, have a number of sufficiently nourishing interpersonal and intimate relationships, be able to pursue a professional or academic activity that is in line with one's goals. Taken together, such a definition of "getting a life" combines both symptom remission and recovery (5).

In the study by McMain and colleagues (6, 7) carried out in Canada, dialectical-behavior therapy was compared with general psychiatric management. The results showed that the frequency of suicidal episodes, the main outcome in this trial, decreased from just below 2 at intake to under .05 at 12 months (end of treatment), for both treatments. These effects are comparable between the groups at 12 months follow-up (7) and consistent results were found for the secondary outcomes which did not differ between the two treatment conditions. On a group level, there is no difference between the effectiveness of DBT and GPM. In an attempt to understand which therapy is the most suitable for which patient profile, Keefe and colleagues (8) re-analysed this dataset using the Personalized Advantage Index (PAI). Six moderator variables were selected and the "best" treatment was identified for each of the moderator, which each represented a specific patient feature. The results indicated that GPM was particularly promising for patients with more general symptoms and more impulsive behaviors, but less depressed and emotional abuse, less dependent personality style and less social maladjustment. These results indicate that while on the group level, the effectiveness of GPM may be comparable to DBT, on the individual level, it may depend on specific clinical features of the patient. These results have important implications for triage and treatment selection.

In line with the dissemination of good-enough practice in psychiatry for borderline personality disorder, a series of studies has been carried out on GPM in Switzerland. Two randomized controlled trials (9, 10) used a brief version of GPM as comparison treatment to a personalized treatment based on case formulation. The initial rationale for selecting GPM in

these outcome trials was to use a guideline-based approach to study the impact of personalization on process and outcome in psychotherapy. The brief, 4-month version of GPM, focused on the discussion of the diagnosis of borderline personality disorder, in addition to treating core problems in terms of the interpersonal hypersensitivity model (11). The results indicated that for general problems (e.g., related to mood, anxiety and anger), interpersonal and borderline symptoms, the pre-post effects over 4 months of using both treatment approaches were systematically large, while the between-group comparisons varied between medium and small, depending on the outcome measure. Importantly, no between-group effects for the change in borderline symptoms was found, which may be interpreted as GPM being "good enough" for reducing borderline systems, but not necessarily the general symptoms. Therapist adherence to GPM principles was overall acceptable, using the General Psychiatric Management Adherence Scale (GPMAS; 12), and predicted between 16% and 23% of the outcome variance (13). Grandjean and colleagues (14), using a machine-learning approach, attempted to profile patients from both trials to learn which patient presentations benefitted the most from brief GPM. They found that patients with a high level of borderline symptoms, only little social maladjustment and younger age benefitted the most. Again, these conclusions are relevant for triage and appropriate treatment selection for patients with variety of characteristics.

In conclusion, these studies indicate that patients with borderline personality disorder, as a form of severe personality pathology, receiving GPM seem to benefit from treatment (see 15 for more details). This seems to be true for a specific sub-group of individuals, in particular those with high general and impulsive symptoms, and borderline symptoms. Patients with more problems in psychosocial adjustment may need more intensive treatment, so the promise to "get a life" may not be achievable as yet, given the current level of evidence.

Mechanisms of change: how is GPM helpful?

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)), which has only recently been extended to psychotherapies for personality pathology (18, 19, 20, 21). Research methodology has improved to allow a rigorous and clinically meaningful test of mechanisms of change associated with functional domains of personality pathology (22). The recent move in the field towards the dimensional model of personality pathology opens new avenues of conceptualization of process research (23).

A mechanism of change can be understood as a generic principle of change which is consistent with the underlying theory and responsible for the change observed in treatment (24, 25). Doss (26) differentiated between a) therapist interventions (i.e., providing psychoeducation on interpersonal hypersensitivity, doing a chain analysis), b) patient in-session processes (i.e., shift in affective response to the therapist intervention, a new understanding of the interpersonal dynamics), and c) the generic mechanism of change in the patient (i.e., out-of-session skill to interrupt unhelpful interpersonal dynamics, out-of-session skill to understand one's and other's emotional response). In an attempt to anchor this model within a) the functional domains of personality pathology and b) to personalize the pathways of change, in relationship to features of the individual case, Kramer, Levy and McMain (19) propose 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 be fostered in session (or out of session) that produce good outcome, develop new intermediate treatment goals and help tighten the focus on the essential functional domains of personality pathology in the individual in treatment. All these measures may eventually contribute to the increase of the effectiveness of treatments.

For GPM, three functional domains have been studied as potential mechanisms of change, a) how to reach an emotional balance in patients, b) moving from problematic social interaction to interpersonal effectiveness and c) the development of a coherent, reality-based narrative.

From emotional dysregulation to emotional balance

Reaching an emotional balance can be as challenging as it is subjectively rewarding for a patient with a personality disorder. In a design which separated the timing of the assessment of the outcome from the timing of the assessment of the process, 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 the sessions 1 and 5 explained the decrease in symptoms observed between sessions 5 and 10 into the treatment. This study assumed that the intensity of an emotion should be regulated, neglecting the more differentiated emotion types contributing ultimately to emotional balance. Berthoud and colleagues (28) analysed in-session patients' emotion types across brief GPM treatments, and compared them to the treatment in which an individualized case formulation, using Plan Analysis, was added to brief GPM. They found that there is a general decrease over the course of treatment in global distress (i.e., a non-specific expression of distress, mixed with some anger and oftentimes intensive frustration and hopelessness), while there is an increase in all other emotion categories over the course of GPM (e.g., specific types of anger, shame and hurt and grief). These processes are related with the symptom decrease. These results indicate that GPM may not only foster emotion regulation, but also emotion transformation, that is the move towards a productive use of emotion as a meaning-making process, when it arises. Kramer and colleagues (29) wanted to know whether change across brief GPM was associated with biological response patterns in the brain, when specific emotions are activated. They developed a paradigm of assessment of self-contempt in borderline

personality disorder, using out-of-session emotion-evoking experiential assessment combined with functional Magnetic Resonance Imaging (fMRI) that used the stimuli from the emotion-evocative assessment (validity coefficients reported in (30) and (31)). Stimuli extracted from these emotion-evocative assessment were then introduced as individualized stimuli into the fMRI. Results from a pre-post treatment analysis showed that BOLD response increased in the putamen in response to the individualized stimuli (compared with negative standard stimuli) at post-treatment. This result may indicate a more intense cognitive treatment of the individualized stimuli in the end of treatment. Changes in neurofunctional response patterns in the bilateral precuneus associated with the individualized stimuli predicted the decrease in in-session, subjectively perceived, emotional arousal in the patients, which in its turn predicted the decrease in borderline symptoms. This pattern of results suggests that emotional balance may pass through the activation of individually relevant, self-contemptuous, contents, which lessen across treatment in the context of a decreased in-session emotional arousal.

From problematic social interaction to interpersonal effectiveness

Social cognitions – the individual's thought processes about 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 of the spontaneous discourse of the patient were not related with symptom changes. Kramer and Gholam (34) re-analysed 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 with better therapeutic alliances over the course of treatment. The "trust-culprit" heuristic was marked by a combination of cognitive errors taking overly responsibility in social interactions, including with the therapist: the more patients expressed biases in thinking in this specific way – problematic in itself –, the better was the therapeutic alliance. This result may bear important

clinical implications when it comes to stimulate collaboration within therapy. Signer and colleagues (35) analysed the social interaction itself as a predictor of change and showed consistently that the activation of problematic social interaction positively predicted the change at the end of treatment, in terms of reduction of interpersonal problems. Interestingly, this effect was larger in the individualized treatment based on the case formulation methodology, compared to the standard GPM. These results indicate that the 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. Using the core conflictual relationship theme methodology to assess in-session social interaction patterns, Kramer and colleagues (36) analysed the in-session pervasiveness (i.e., level of generalization across interactions) of these social interaction patterns. These researches showed that the level of generalization of the self's response to the internal conflict lessens over the course of GPM. While these changes were not related with general symptoms (e.g., related to problems in mood, anxiety or anger), they predicted decrease in borderline symptoms in the end of treatment. In conclusion, there is some evidence that changes in social interaction patterns contribute to a healthy pathway of change in symptoms in borderline personality disorder more broadly.

From inconsistency to coherent, reality-based narratives

The functional domain of incoherent, pseudo-psychotic and dissociative presentation is central for some forms of borderline personality disorder, but has been neglected in research. From an in-session process research perspective, Kramer and colleagues (37) analyzed the coherence of emotion-based narrative change across brief GPM, by assuming that the early decrease in in-session problematic emotion-narrative process markers predicted the later symptom decrease. The model was statistically significant for the decrease in general symptoms after session 5 into the brief GPM. This result indicates that there is first evidence

that GPM may work also through the progressive development of coherent, reality-based emotion-narrative.

Conclusions and recommendations for future research on GPM

The present paper aimed at addressing the question whether good psychiatric management has a "good enough" empirical basis. While this rhetorical question echoes John Gunderson's reference to Winnicott's "good enough mother" and means that highly specialized psychotherapies for borderline personality disorder may be supplemented by a more generalist, straightforward and easy-to-implement, therapy approach which may a) avoid doing harm and b) be effective and sufficient for many patients with severe personality pathology, and in particular borderline personality disorder. In terms of outcome, the evidence suggests that treating patients with GPM principles may potentially produce change in borderline and general symptoms. In order to more firmly conclude about the efficacy in reducing these problems, randomized controlled trials comparing GPM to treatments as usual (or community-based treatment that are non-specific to borderline personality disorder) are urgently needed. Only with this formal demonstration of effect can GPM be considered as an evidence-based treatment for borderline personality disorder, or more broadly severe personality disorders (38, 39, 40).

In order to understand how psychotherapy works, it is absolutely needed to study processes and mechanisms of change, within and out-of-session. Initial evidence for in-session processes explaining the effects of GPM encompass changes in coping, emotion transformation processes, socio-cognitive processes (interpersonal heuristics, interpersonal patterns, social interaction), as well as changes in emotion-based narrative. There is only one study to date which has tested, in controlled environment, the out-of-session mechanisms of change associated with GPM: by assessing the change in self-contempt in an emotion-evocative task, as well as in an fMRI environment: this research breaks new ground to

understand the impact of a clinical intervention on the generic skills and new insight patients learn through psychotherapy.

Changes observed in psychotherapy take place in the context of a trusting therapeutic relationship: it is notoriously difficult for these patients to engage in such a trusting relationship. Ruptures in the therapeutic alliance are the norm and represent excellent 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. In the current review, we have not discussed the literature on the therapeutic alliance in good psychiatric management for borderline personality disorder (see 41, 10, 42).

Last but not least, we need to note that studies referred to were conducted in high-resource countries, such as Canada and Switzerland. We hope to see more diverse research emerging in a variety of real-world contexts, on both the outcome and mechanisms of change in GPM, which should contribute to clarify the impact on the actual clinical practice these principles have on the level of the patient's process of recovery.

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