Commentary: A method of training therapists to treat patients with borderline personality disorder

«Good enough» training in clinical practice for BPD?

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Training psychiatrists, psychologists and psychotherapists in an evidence-based treatment, until its delivery is "good" (adherent) and competent, is not an easy task. Evidence-based treatments are complex models of psychotherapy and require a rather long process of training and supervision for therapists to reach good practice. However, the adherent and competent delivery of a treatment is essential, as it helps to avoid unsound and approximate practice with unclear consequences. Training for treating patients with borderline personality disorder (BPD) illustrates well the typical problems related to implementation of evidence-based practice in various communities and the important role of a "good enough" training as part of an integrated approach to psychotherapy training. We will take the Swiss context as example, but our conclusions might hold true across European countries.

There are several arguments favouring "good enough" training as part of an integrated approach to psychotherapy training. (1) Given the high costs of training, it seems unlikely that all mental health practitioners will eventually be fully trained in an evidence-based psychotherapy form [1] such as dialectical-behaviour therapy (DBT), mentalisation-based therapy, or transference-focused psychotherapy. (2) Empirical research from the last 20 years has accumulated and we have gained more specific knowledge about the aetiology, psychopathology and course of BPD, and about the process and outcome of its treatments; a significant portion of these discoveries are valid across contexts. It is therefore important to disseminate this knowledge to the treaters, patients and families. (3) Implementation of evidence-based treatments may not be effective if done in a unilateral way: a more complex – stepped care – approach may be used [2]. The lattermay involve offering the patients a first-line, minimal treatment, in many cases short-term. This treatment aims for a "good enough" change and avoids deterioration. Then, in certain selected cases, an evidence-based psychotherapy is proposed. Research has shown that initial changes may be found after 4 months on indexes of general symptoms (depression, anxiety) and increase initial therapeutic collaboration [3].

Therefore, it seems important to propose an easily accessible and synthetic training module that integrates these constraints and fosters evidence-based "good enough" general clinical management (good psychiatric management; GPM) for patients with BPD [4], as part of the basic training of all future psychotherapists – psychiatrists and psychological psychotherapists, as well as all other mental health workers. GPM was developed on the basis of John Gunderson's clinical wisdom anchored in the core psychopathology of BPD, the accumulating research on psychiatric intervention and the need of dissemination of a clinically meaningful approach. It was demonstrated that GPM had comparable effects on all outcome measures, when compared with DBT over 1 year, effects which were maintained at 2-year follow-up [5].

GPM requires the clinician to develop a straightforward, flexible, pragmatic and eclectic intervention style that offers the patient psychoeducation on BPD, its course and treatment. The clinician adopts a doubtful and thoughtful stance and accepts that the therapeutic relationship is at the same time "real" (taking place between two humans) and "professional" (potentially idealised and devalued). The patient is expected to take responsibility for his/her actions, which are analysed within an interpersonal framework, and change in treatment is expected from day one. These principles are implemented by using an active therapist stance, by offering psychoeducation related to the disorder, its course and treatments, by adopting a thoughtful, deepening and doubt-provoking intervention style, and by integrating different interventions as a function of the patient's current state of mind. Most importantly, the central focus of the treatment is to build vocational or scholarly activities in the patient's life [4].

A "good enough" training in the practice of GPM enables the following. (1) It helps to overcome negative attitudes and stereotypes related to the so-called "untreatability" of BPD [1, 4]. (2) It helps to promote what is necessary for young clinicians and seasoned therapists alike to face difficult interactions with patients with BPD. (3) Because of the cost-effectiveness of its implementation (clinical training in GPM requires less resources than a specialised training), very wide and rapid dissemination is achievable. (4) Switzerland is a particularly good example of implementation, because of the integrated training available for psychiatrists, psychotherapists and psychological psychotherapists. In this context, "good enough" clinical practice may be differentiated from specialised psychotherapy, but both may be practiced by the same clinician: this situation may synergistically contribute to the effectiveness of both treatments. Given this, implementation of a single psychotherapy model different from existing clinical practice seems inappropriate within a particular training context, but a multi-component, stepped-care and integrated training approach is promising, effective and lasting. (5) GPM helps to find a common language between therapists from different therapy schools, such as psychodynamic and cognitive-behavioural, and different professional backgrounds. As such, we feel "good enough" training helps teams to grow and work together. (6) Finally, a generalistic approach to training may enable competent delivery of minimal intervention standards to health workers who do not directly work in psychiatry, but are confronted with patients with BPD in their practice (emergency room practitioners, general practitioners, family therapists).

We propose GPM as a first-line training component for general (integrated) psychiatric and psychotherapy treatment of patients with BPD and we argue that the current situation in Switzerland is a particularly accurate illustration.

References

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