

GROUP THERAPY FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDERS : A REVIEW

JOSÉ GUIMÓN AND WENDY DÁVILA

Kernberg related personality disorders to early defence mechanisms against sexual and aggressive drives and highlighted the role played by the dysfunctions in object relations, established during early infancy. It is in childhood when the patient sets in motion pathological defence mechanism (dissociation, acting out, projective identification etc.). Later studies contend that most core symptoms of the disorder, such as: a diffuse sense of self, bursts of rage, unstable interpersonal relationships, feelings of emptiness and abandonment, chronic fears of, and an intolerance for aloneness, have their roots in an impaired organization of the underlying attachment (in Bowlby's sense). Levy et al underline that individual differences in the attachments of adult people are rooted in the early patterns of interaction with caregivers and the completion of a number of attachment measures, revealed six factors that clustered into three groups (an avoidant attachment pattern, a preoccupied attachment pattern, and a fearfully preoccupied pattern).

These patients are difficult to manage in individual analytical psychotherapy, due to their instability, which is frequently related to a loss of self-esteem and identity confusion. The course of therapy tends to be disturbed by intense transferences and various acts, such as suicide attempts, attacks of rage, and self-mutilation caused by suicidal thoughts. Kernberg recommended confronting these patients and interpreting their negative transference early on, whereas other authors advise therapists to limit themselves to acting as a holding environment for the patient and avoid interpretations. There is a high percentage of drop-out in these patients.

1. FROM THE CIRCLE TO THE COMMUNITY

Indeed, group therapy offers the advantages of being less expensive; making transference easier to manage; and producing an improvement in ego functioning and interpersonal functioning, and a drop in the patient's regressive tendencies. Moreover, these

patients are more likely to take advice or have confrontations with other patients than with the therapist, and they have the possibility to relate with them on an equal level.

Dawson proposes a program with the aim of « managing emotions » in which therapists show themselves as permissive even if they forbid acting out. Regular attendance at meetings is not obligatory, which means that only 30% of regular presence which forms the nucleus of patients is more or less constant, while there exists in addition a much greater cloud of patients who show up from time to time in the group searching for occasional help.

1.1. Multidimensional programmes

Group therapy is frequently part of a multidimensional programme, including medication and different types of psychotherapy. In relation to this, some fairly specific treatments have been used, including serotonin reuptake inhibitors, mood stabilizers, and neuroleptics at a low dose level.

The therapeutic groups tend to be heterogeneous in composition although the present most popular programs Linehan's Dialectical Behavioural Therapy and Bateman's are homogeneous. The orientation of groups tends to be eclectic, and although open psychodynamic groups are the most frequent, others focus on such aspects as acting out, splitting, countertransference, and the focus and eroticisation of relationships.

1.2. Part time or full time hospitalization

Because of these risks of acting out, the therapist must be able to count on a support system to offer more holding for these kinds of patients, i.e. a hospital unit (which should be avoided as much as possible in order to not embark on a prolonged and counterproductive relationship with the institution) or a day hospital.

Recently, the work under a psychodynamic perspective by Bateman and by Bateman and Fonagy have shown favorable results with treatment based on dynamic psychotherapy in a day hospital.

Springer, based on existing literature, proposes a framework in which an effective, short-term group treatment is organized by using it for a short term on hospitalized patients.

1.3. Therapeutic communities

Therapeutic communities have had difficulties in surviving in the medicalized atmosphere wrought by "managed-care" strategies which are prevalent in most Western countries .

However, some authors such as Dolan et al. used a complete group program with hospitalized patients. Similarly, Hafner and Holme made a prospective study with 48 residents of a therapeutic community with borderline personality disorders.

On our side , over the past 20 years we have developed a certain number of group programs or "decaffeinated therapeutic communities" . These programmes have been developed in many psychiatric services with an orientation towards community therapy in a dozen different care units, (short-stay units in general hospitals, rehabilitation units, day hospitals) for severe psychiatric patients, including many with borderline personality disorder, both in Spain and in Switzerland (Guimón, 2001). They include, at the minimum, a daily medium-sized group bringing together patients and staff and a "small" group of patients, with a dynamic orientation but with occasional cognitive-behavioral tendencies as well as group activities (« group work » in Foulkes' sense).

The Therapeutic community approach should be an antidote to the trend toward managed care for this kind of patients. Effectively, some borderline patients with serious symptoms (incompetence, suicidality, dependency) who suffer from a feeling of profound insecurity will continue to need long-term, intensive therapy and we should display some reticence when faced with attempts to reduce or dilute the services we offer (Campling & Dixon Lodge, 1999a, 1999b; Campling & Haigh, 1999). A training process which corresponds to therapeutic community principles should encourage the growth and differentiation of patients and, as Campling and Haigh warn, avoid indoctrination and infantilization that are typical of medical training but also of psychoanalytical training. Although the philosophy of therapeutic communities has become especially widespread over the last few years in half-way institutions, the hospital-based therapeutic community will continue to justify itself. Effectively, it combines socio-therapeutic treatment and psychotherapeutic treatment with the advantages of a hospital context ; it has shown itself, moreover, to be useful in the treatment of borderline personality disorder and the rehabilitation of certain delinquents.

2. RESULTS

The group therapy was found to be as efficient as individual therapy in the previously mentioned program of « managing emotions » and the patients who participated in groups showed better treatment compliance. Furthermore, a controlled study compared individual and group psychotherapy showed better results with this second approach. Wood et al. compared group therapy with the routine care for adolescents, (who had deliberately self harmed and were in their majority borderline). They found that those under group therapy were less likely to be "repeaters" although they did not differ, however, in their global outcome. Hawton et al (Hawton et al., 2002) evaluated all randomised controlled trials regarding the effectiveness of treatments of patients who have deliberately self-harmed and found reduced rates of further self-harm for depot flupenthixol vs. placebo and for dialectical behaviour therapy vs. standard aftercare

As for the theoretical orientation, significant positive results have been found with the cognitive-behavioral approach of Linehan named the “dialectical behavior therapy” (DBT). The method was first initiated for young women who were parasuicidal and was then extended to persons with behavioral problems to resolve « dialectic » failures. Effectively, from a theoretical point of view, Linehan made reference to this dialectic reasoning which brings into opposition poles such as emotional vulnerability vs. invalidation, active passiveness vs. competency, and demonstrative crises vs. emotional inhibition.

DBT programs combine individual and group approaches in problem solving and in training in skills. In the psychoeducational groups, patients are taught a certain number of skills in regulating emotion, interpersonal functioning and stress tolerance. The patients take part in these groups during at least one year, and then take part in help groups to reinforce the application of skills. At the individual and concomitant therapy, which lasts at least one year, the patients are taught to integrate these skills into daily life. Rules to generalize the apprenticeship to the outside world (even with the use of the telephone) are proposed. The group is closed or, at the maximum, slowly opened.

The psychoanalytical approaches are especially based on the theory of object relations. Most of the approaches have been developed in hospital environments or in half-way centers. It is principally the work of Kernberg that uses the psychoanalytical model of object relations (Kernberg, Kibel, Russakoff) in the program of “Transference Focus Psychotherapy” (TFP).

The accent is placed on increasing the fortress of the ego and improving the experience of reality with an attempt at internal reconstitution. From a technical point of view, the splitting mechanism is rather more reinforced than struggled against and the open exteriorizing of aggression realization of group interpretation, based on the « here and now » favoring cohesion, is encouraged.

Bateman and Fonagy compared the evolution of 19 patients who were treated through hospitalization partially oriented from a psychoanalytical perspective, with the same number of patients who had received a general psychiatric treatment. Self-mutilating behavior and suicide attempts decreased during the 18-month program, in the former, in contrast with the latter. In the same way, the average hospital stay was shorter than for those who followed a general treatment.

As for the therapeutic community oriented programs, Hafner and Holme (Hafner & Holme, 1996) led a study in order to determine which elements of the program were most useful. They discovered a reduction in significant symptoms on the Brief Symptom Inventory took place at discharge after an average stay of 64 days and the rates of admission to hospital fell in a significant fashion during the year after discharge. The patients rated group therapy as the most useful element of the program. Sabo et al. followed up, in a prospective fashion, 37 hospitalized patients, suffering from borderline personality disorder, over a five-year period, to evaluate the changes in two forms of self-destructiveness. They noted that suicidal conduct diminished significantly, that self-aggressive conduct presented a certain tendency but not a significant decrease and that aggressive ideation (both suicidal and self-destructive) did not decrease in a notable fashion. Dolan et al evaluated the impact of therapeutic community oriented treatment in 137 patients hospitalized on the principal symptoms of personality disorder. They noted a significantly greater improvement in those treated than in the group « not admitted » having a significant positive correlation with the length of treatment.

Finally, Schimmel underlines the efficacy of therapeutic community treatment for patients suffering from borderline personality disorder..

In a recent a naturalistic study we have evaluated the outcome of 109 patients (64,2 % Borderline and 35,8% Non-Borderline) treated in a day unit we organized in 2003 in Bilbao. with an average hospital stay of 50 days. We find an excellent attendance with a lack of differences between BPD and Non BPD, contradicting our hypotheses, based in the literature,

that BPD would have a more irregular attendance. In fact, the drop-out rate was smaller in BPD than in Non-BPD ($p=0,499$). There was an important improvement of the symptoms without differences between BPD and Non-BPD. However, in the BSI, BPD patients had a larger range in symptoms. There was also an important improvement in global functioning without differences between BPD and Non-BPD in the relationships with others. However BPD obtained a statistically significant higher improvement than Non-BPD in "daily life activities" ($P=0,035$). In view of the results

we underscore the need for more naturalistic studies and, we favour eclectic, brief, dynamic, day hospital approaches with heterogeneous patients as an optimal emergency approach for people with BPD

A recent *Cochrane review* identified seven studies involving 262 people, and five separate comparisons. In the studies comparing dialectical behaviour therapy (DBT), with treatment as usual, no difference was found in the outcome of hospital admissions in the previous 3 months, or in the outcome 6 months after being discharged. (Though, self harm or parasuicide may decrease at 6 to 12 months). One study detected statistical difference in the average scores of suicidal ideation at 6 months, in favour of people receiving DBT, compared with those allocated to treatment as usual. There was no difference in the outcome of leaving the study early. For the outcome of interviewer-assessed alcohol free days, skewed data are reported and tend to favour DBT. When a substance abuse focused DBT was compared with comprehensive validation therapy plus 12-step substance misuse programme no clear differences were found for service outcomes or leaving the study early. In similar fashion DBT is compared with client centred therapy no differences were found for service outcomes. However, fewer people in the DBT group displayed indicators of parasuicidal behaviour. There were no differences for outcomes of anxiety and depression but people who received DBT had less general psychiatric severity than those in the control group. Finally, this one relevant study reports skewed data for suicidal ideation with considerably lower scores for people allocated to DBT. When psychoanalytically oriented partial hospitalization was compared with general psychiatric care the former tended to come off best. They also observed that people who received treatment in a psychoanalytic orientated day hospital were less likely to be admitted into inpatient care when measured at different times. Also, fewer people in psychoanalytically oriented partial hospitalization

needed day hospital intervention in the 18 months after discharge. In contrast, more people in the control group took psychotropic medication by the 30 to 36 month follow-up, than those receiving psychoanalytic treatment. The anxiety and depression scores were generally lower in the psychoanalytically oriented partial hospitalization group, as were the global severity scores. The patients receiving psychoanalytic care in a day hospital had better social improvement and social adjustment, using the SAS-SR at 6 to 12 months, than those in general psychiatric care, though the rates of attrition were the same

These authors suggest that some of the problems frequently encountered by people with borderline personality disorder may be amenable to talking/behavioural treatments, but all therapies remain experimental. The studies are too few and too small to inspire full confidence in their results, and the findings must be replicated in larger 'real-world' studies.

3. PSYCHODYNAMIC ASPECTS

Different authors have compared Kernberg and Linehan's approaches. In both, the therapist is strongly committed, even if the attitude of Kernberg is neutral and that of Linehan rather active with attitudes of reinforcement. The expression of aggressiveness is encouraged by Kernberg, while Linehan does not encourage it, and is not interested in the here-and-now of the group, or in group phenomena

Concerning the Therapeutic Community approach, in the hospital milieu, (and also in half-way institutions), the treatment is carried out in settings where several care-givers interact. Adshad , in light of the theory of attachment, reported that the hospital milieu provides security only if care-givers are capable of tolerating, both the external demands of the system, and the internal demands of patients. He pointed out that therapeutic relationships between staff and patients are only repetitions and recreations of internal object relations and that responses from the team to splitting and to projective identification can sometimes be negative. He indicated that a certain number of negative reactions can be detected through the patronizing and contemptuous way in which the care-giver may sometimes express him/herself to the patient. He adds that certain excessive reinforcements of the regulation of services, for example: the inappropriate use of restriction on movement, may be the result of this contrary attitude in personnel. He also remarks how the new organization of cost containment, particularly in the managed-care system, and the interference of insurance

companies, comes to be added to the conflict between therapist and patient. Finally, he reminds the problems in the organization of the structure of the unit, such as inadequate accounting practices, lack of leadership, difficulties in communication and violation of boundaries, can seriously aggravate the condition of patients.

The program developed in the Francis Dixon Lodge is an example of the above issues. The patients are generally hospitalized because of their destructive fashion with which they express their mental pain. After three weeks of hospitalization, they propose the psychodynamic formulation which includes predictions on the transference reactions that we can expect and that try to cover the self-aggressive behavior (feelings of abandonment, trigger situation, etc.). They try to create a therapeutic relationship in which the patient feels sufficiently reassured to explore avenues of new relationships, while allowing him/her access to the horrors of the past, (which may carry so much negative emotion that they could even endanger the relationship). In addition, they consider that acting out is an expressive and defensive function and that even a more self-destructive behavior can be an attempt to avoid another catastrophe (psychosis, hetero-aggression, etc.), which can be experienced as more destructive to their own integrity.

These patients, because of their poor self-esteem, do not know how to ask for help in an appropriate manner, and do so by provoking crises, which causes the therapeutic team to counter-react. They explain to patients that they must learn to talk about their suicidal feelings or their ideas of self-mutilation; adding, that they will try to be tolerant, but that they will also expect them to modify their behavior. And through the whole intervention, they try to avoid the feeling of omnipotence of the patients when they trigger self-aggressive activities, giving special attention to phenomena of hostile and envious dependency, by trying to avoid or to manage negative therapeutic reactions.

Initially, two factors present in the course of treatment in certain psychiatric hospitals were recognized: "containment", (in Bion's sense), which builds a feeling of security in the face of the infantile pain, the rage and the despair frequently re-experienced in the therapeutic community; and the "structuring the environment" to make it less uncertain, and to facilitate modifications in the ill-adapted behavior of the patient.

Other factors involved in the efficacy of a therapeutic milieu have been described, notably: the "support" of whatever the foster patients can personally invest in the treatment

plan to fight against passiveness; the promotion of the acceptance of the expression of their pathology, ("validation"), that allows patients to assume their individuality; and the "implication", the mechanism through which patients are encouraged to interact with their environment, to escape from passiveness and to collaborate.

These different mechanisms act in a specific fashion for different patients. Thus, containment can be necessary for borderline patients in an acute phase, confused and impulsive, but can have a negative effect later. Support can be very useful for depressed or frightened patients, but may be harmful for borderline patients. And, validation can be very useful for paranoid and borderline patients, but can be dangerous if they are suicidal patients

In addition, from a psychoanalytical point of view, certain ingredients derived from theories of relation to the object, of the psychology of the ego, and of the group analysis represent the quintessence of therapeutic communities and explain their therapeutic effect with borderline patients.

In following a developmental sequence, several therapeutic ingredients have been described, of which the first was "the attachment". The theory of attachment shows that if the link with the mother has not been reassuring, the adult will lack confidence in him/herself, which is notably the case of certain patients suffering from borderline personality disorder. The therapeutic community creates a culture in which belonging is highly prized and where the members themselves are validated, which is reassuring for the patient. But, for an individual to develop, he/she must be able to confront other complex experiences, of love, hate, anger, frustration, sadness, attack, defense, comfort, etc., facilitating disillusion regarding the fantasy of a symbiotic fusion and the early attachment and rendering the patient capable of « growing up and leaving home ». In this sense, the therapeutic community offers experiences of inclusion, (a process of derivation and evaluation), and of departure, (rituals of farewell, etc.).

Another fundamental therapeutic factor of development is of course the already mentioned concept of "containment", which relates to the « mothering element » of these institutions. But there also exists a « paternal element » extremely important for borderline patients that consists of establishing limits and rules, and reinforcing boundaries, which contradict, in a certain fashion, the notion of « permissiveness » demanded in a therapeutic community.

Once the therapeutic community has mastered primitive preverbal work with a patient, a fundamental challenge consists in establishing "communication", in the form of contacts with other patients and care-givers. This allows them to build mutual understanding through the use of "symbolic representations" and the process of "identification". To this purpose, there must exist a "communal identity" which consists in a set of intimate relationships forged through the participation of all the members in therapeutic, social and informal activities within a « culture of enquiry ». Groups that are stable and protected with well-defined boundaries make this process possible.

Another factor specific to therapeutic communities is represented by the compromise of obliging patients, who accept that all interpersonal interaction belongs to all the members of the community. Effectively, everything that goes on in the community can be utilized from a therapeutic point of view, leading then to an inseparable union between « living and learning » .

On the other hand, there exists, in therapeutic communities, a basic belief according to which the patient's unconscious is a better judge than the analyst's of the direction therapy should take. Thus, it emerges that the most important therapeutic effect is brought into being by the patient, not by the therapist. The lack of symmetry between the therapist and the patient is accepted, but the automatic assumption of the therapist's superiority is rejected by most borderline patients. This attitude fosters accountability in patients, who then assume responsibility for their own therapeutic process, which facilitates its improvement but can also be a source of ambivalence, for example engendering feelings of guilt.

The majority of severely affected borderline patients have a fragmented internal world, with disorganization of their identity and of their mental processes. Disorganized institutions threaten to increase disorganization in their members who, in turn, will disturb the institution. Effectively, patients project their difficulties onto the community that surrounds them, and introject elements of organization into that community. The concept of "internalization of object relations" is essential in the treatment of borderline patients.

SUMMARY

Group therapy is frequently part of a multidimensional programme, including medication and different types of psychotherapy. The therapeutic groups tend to be

heterogeneous in composition although the present most popular programs Linehan's Dialectical Behavioural Therapy and Bateman's are homogeneous. The orientation of groups tends to be eclectic, and although open psychodynamic groups are the most frequent. Because of these risks of acting out, the therapist must be able to count on a support system to offer more holding for these kinds of patients, i.e. a hospital unit or a day center.

A few naturalistic studies underline the efficacy of therapeutic community treatment for patients suffering from borderline personality disorder. In view of the results a personal research the authors underscore the need for more naturalistic studies and the we favour eclectic, brief, dynamic, day hospital approaches with heterogeneous patients as an optimal emergency approach for people with BPD

The efficacy of several therapeutic factors involved in the therapeutic community approach, in the hospital milieu and in half-way institutions are finally discussed in light of the theory of attachment,

The authors conclude that the therapeutic community approach should be an antidote to the trend toward managed care for this kind of patients. Effectively, some borderline patients with serious symptoms (incompetence, suicidality, dependency) who suffer from a feeling of profound insecurity will continue to need long-term, intensive therapy.

RESUMEN

La terapia de grupo, junto con la terapia individual, es una herramienta clave en el tratamiento de los TLP. Esta terapia es frecuentemente parte de un programa multidimensional, incluyendo la medicación y otras formas de tratamiento. Los grupos terapéuticos tienden a ser heterogéneos en su composición, aunque los programas más populares en la actualidad, (los de Linehan, Kernberg y Bateman), son homogéneos. La orientación de los grupos tiende a ser ecléctica, y aunque los grupos psicodinámicos abiertos son los más frecuentes.

Se han hallado resultados positivos significativos con la terapia cognitivo-comportamental de Linehan que combina abordajes grupales e individuales en la resolución de problemas y en el entrenamiento en habilidades. Esta terapia "dialéctica comportamental", ha mostrado ser eficaz para la disminución de los índices de suicidio en pacientes con TLP,

como demuestra un estudio controlado de Linehan en 2006), que comparaba la TDC y el tratamiento comunitario por expertos.

En general, los abordajes psicoanalíticos están basados en la teoría de las relaciones objetales. Los trabajos recientes de Bateman y Fonagy muestran resultados favorables con un tratamiento basado en una psicoterapia dinámica (con una técnica que denominan “mentalización”) en un hospital de día. Los comportamientos automutiladores y los intentos de suicidio decrecieron durante los 18 meses de programa y también disminuyó la estancia hospitalaria media en contraste con aquellos que habían seguido un tratamiento general.

Una *revision* reciente de *Cochrane*, (Blinks et al. 2007) identifica siete estudios que implican a 262 personas, y con 5 comparaciones distintas. Los autores sugieren que algunos de los problemas con los que usualmente se enfrentan las personas con un trastorno límite de la personalidad pueden ser susceptibles de tratamientos verbales/comportamentales. Sin embargo, todas las terapias continúan siendo de carácter experimental, y los estudios son demasiado escasos y reducidos para suscitar una plena confianza en sus resultados. Estos hallazgos requieren replicarse en estudios mayores más semejantes al “mundo real”.

No existen estudios controlados acerca de la efectividad de los programas de las Comunidades Terapéuticas, y la multiplicidad de variables que intervienen en el proceso terapéutico en estos ambientes hace que este tipo de abordaje sea poco probable. Existen algunos estudios “naturalísticos” que muestran la eficacia, entre ellos, unos realizado en Bilbao en que se muestra la eficacia de un programa de día de 50 días, de media de duración de cuatro horas semanales.

REFERENCES

- Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *Am J Psychiatry*, 156(10), 1563-1569.
- Buie, D. H., & Adler, G. (1982). Definitive treatment of the borderline personality. *International Journal of Psycho-Analysis and Psychotherapy*, 9(51-87).
- Clarkin, J. F., Marziali, E., & Munroe-Blum, H. (1991). Group and family treatments for borderline personality disorder. *Hospital Community Psychiatry*, 42, 1038-1043.

- Dawson, D. F., & MacMillan, H. L. (1993). *Relationship Management of the Borderline Patient*. New York: Brunner/Mazel.
- Francés, A., First, M. B., & Pincus, H. A. (Eds.). (1997). *DSM-IV, Guía de uso*. Barcelona: Masson, Barcelona.
- Gabbard, G. O., Horwith, L., Frieswyk, S. H., & al., e. (1988). The effect of therapist interventions on the therapeutic alliance with borderline patients. *Journal of the American Psychoanalytic Association*, 36, 697-727.
- Gunderson, J. G. (1994). Building structure for the borderline construct. *Acta Psychiatrica Scandinavica. Supplementum*, 379, 12-18.
- Hawton, K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., & van Heeringen, K. (2002). *Psychosocial and pharmacological treatments for deliberate self-harm (Cochrane Review)* (Vol. 1). Oxford: Update Software.
- Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books.
- Horwitz, L. (1987). Indication for group psychotherapy with borderline and narcissistic patients. *Bulletin Of The Menninger Clinic*, 51, 248.
- Kernberg, O. F. (1980). Neurosis, psychoses and the borderline states. In A. M. Kaplan & F. A. M. & J. Sadock (Eds.), *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins.
- Klein, R. H. (1993). Short-term group psychotherapy. In W. Wilkins (Ed.), *Comprehensive Group Psychotherapy* (pp. 256-270). Baltimore: Williams & Wilkins.
- Kretsch, R., Goren, Y., & Wasserman, A. (1987). Change patterns of borderline patients in individual and group therapy. *International Journal of Group Psychotherapy*, 37(1), 95-112.
- Linehan, M. M. (1987). Dialectical behavior therapy for borderline personality disorder. Theory and method. *Bull Menninger Clin*, 51(3), 261-276.
- Oakley-Browne, M., Adams, P., & Mobberley, P. (2002). Interventions for pathological gambling (Cochrane Review). *The Cochrane Library*(1).
- Perry, J., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *Am J Psychiatry*, 156(9), 1312-1321.

- Schreter, R. K. (1970). Treating the untreatable: a group experience with somaticizing borderline patients. *International Journal of Psychiatry in Medicine*, 10, 205.
- Schreter, R. K. (1978). Treating the untreatables: identifying the somaticizing borderline patient. *International Journal of Psychiatry in Medicine*, 9, 207.
- Springer, T., & Silk, K. R. (1996). A review of inpatient group therapy for borderline personality disorder. *Harvey Review of Psychiatry*, 3(5), 268-278.
- White, P., Bradley, C., Ferriter, M., & Hatzipetrou, L. (2002). Managements for people with disorders of sexual preference and for convicted sexual offenders (Cochrane Review). *The Cochrane Library*, 1.
- Wood, A., Trainor, G., Rothwell, J., Moore, A., & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *J Am Acad Child Adolesc Psychiatry*, 40(11), 1246-1253.

