Small STEPPS: The provision of, and changes to, an emotional regulation group for women in a community mental health setting in the UK

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Abstract: Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a manualised group programme aimed at supporting adults who experience difficulties with emotional regulation and who may meet the diagnostic criteria for Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (called Emotional Intensity Disorder within the course). It has been adapted for use in primary care and young people’s services, but its provision is relatively new in the UK and less widespread than that of DBT (Dialectical Behaviour Therapy) groups. Alongside a mental health nurse colleague, we facilitated a twenty week closed group based on the STEPPS programme, for 7 women, all of whom were on a Community Recovery Team caseload within secondary mental health services. We made significant practice changes to the model however, arising from our own ideological positions in relation to BPD as a diagnosis and to some of the course material, practical constraints and our experiences with the group week by week and their specific needs. Here we provide an account of our experiences and those of group members, with a view to supporting the provision of similar groups within mental health teams, particularly women’s groups.

Keywords: Borderline Personality Disorder (BPD); Emotionally Unstable Personality Disorder (EUPD); women; mental health; Systems Training for Emotional Predictability and Problem Solving (STEPPS); groupwork; group work

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Introduction

This article is a practice account of the experiences of a Social Worker and a Clinical Psychologist facilitating a female-only Systems Training for Emotional Predictability and Problem Solving (STEPPS) group within a community mental health team in the UK. It outlines the scope of existing feminist critiques of Borderline Personality Disorder (BPD), with which we largely align ourselves and goes on to consider the implications of this for our groupwork practice. Whilst others have written about feminist therapeutic practice in mental health services with women with BPD (Eastwood, 2012), this article focuses specifically on the facilitation of a STEPPS group, working from a manualised programme which adopts neither the critical or feminist stance which we take as practitioners. It describes the tensions caused by this and considers the ways in which we attempted to deliver the model as authentically as possible and with what results. We hope that our experiences will be of use to people who may be either facilitators or members, or both, of a similar sort of group.

Borderline Personality Disorder: A contested diagnosis

BPD or Emotionally Unstable Personality Disorder (EUPD) is a controversial and contested diagnosis. Indeed, the validity of ‘personality disorders’ as a psychiatric diagnostic category has been widely questioned (Roth and Fonagy, 1996; Lewis and Appleby, 1998; Pilgrim, 2001), though they are largely accepted today within mainstream psychiatry, where certain types, including BPD, are ubiquitous. BPD first appeared diagnostically over 30 years ago, although early theories of personality type can be traced back to ancient Greece and psychiatric documentations of abnormal personality types to figures such as Pinel, Esquirol and Pritchard in the 18th and 19th centuries (Crocq, 2013). Many of the critiques of personality disorders are similar to those within anti-psychiatry (Szasz, 1972) or critical psychiatry concerning issues such as labelling and medicalization, but critical analyses of personality disorders and BPD in particular tend to pay most attention to issues of gender and social morality as biases relating to diagnosis (Bjorklund, 2006).

BPD critiques note both the over-representation of women, who
comprise almost 80% of those who receive a diagnosis (a trend which appears to be consistent across countries) and that these women tend to have abuse and trauma histories (Proctor and Shaw, 2005). In much the same way as anti or critical psychiatry, proponents are concerned about the ways in which diagnoses may function to close down our ability to listen to the possible meanings contained within people’s experiences of distress and its enactments. Personality disorder critics, largely from a feminist perspective, argue that the act of giving such a diagnosis reduces our focus on the cultural, political and socio-economic conditions which enable such widespread violence against women to take place. A BPD diagnosis thus acts as lazy shorthand, obscuring the realities of such violence. Such analyses are also critical of gendered power relations within a society that depends upon social constructions of masculinity and femininity and which, uncritically, links these gendered categories to sex and many have suggested the diagnosis to be a misogynistic go-to for women experienced by clinicians to be ‘difficult’, ‘annoying’ or ‘emotional’ (Becker, 2000; Wirth-Cauchon, 2001; Skodol and Bender, 2003; Proctor and Shaw, 2005; Potter, 2006; Potter, 2009; Watts, 2016). In such a vein, Wirth-Cauchon argues that the diagnosis itself is the medicalisation of women’s self-destructive feelings and behaviours ‘that lie at the extreme end of a range of responses to gender contradictions and violence in late modern society’ (Wirth-Cauchon, 2001, p.211).

This includes considering the cultural legitimisation of men’s anger and physicality over women’s and its impact on a broader understanding of ‘appropriate’ or ‘normal’ behaviour and the ways in which all ‘mental health issues’ are viewed through gendered, racial, heteronormative and other lenses that perpetuate existing oppressions, while simultaneously making claims to objectivity. What this means in practice is that people presenting in the same ways will acquire different psychiatric diagnoses. It also means that mental health services often play a role in re-traumatising people by replicating abusive power dynamics common in childhood abuse, through the acts of silencing and not believing. The user-led group Recovery in the Bin and affiliated group PD in the Bin, whose members also include academics and professionals critical of the ‘Recovery movement’ as it is currently implemented, wrote a list of ways to avoid getting a diagnosis of BPD/EUPD and although tongue in cheek, it is frighteningly accurate, beginning as it does with ‘try not
to be female’ (PD in the Bin, 2017).

Despite its controversy and calls from some prominent voices to get rid of the diagnosis (Watts, 2016) it persists and seems here to stay, at least for a while. Indeed, many mainstream NHS mental health services in the UK are developing personality disorder specific services, for which the key arguments appear to be around the ‘disproportionate’ amount of resources that people with these diagnoses take up, with BPD/EUPD apparently taking up the majority of these resources. There is also an implicit (and sometimes explicit) assumption that as it is ‘behavioural’, people with BPD/EUPD require a different response, care pathway or ‘treatment’ from those suffering from ‘severe and enduring mental illness’, the usual route into the care of secondary mental health services in the UK. One which seeks to not ‘indulge’ the behaviours and instead adopt a clearly boundaried approach in an attempt to stop these problematic behaviours. Yet the numbers of people diagnosed continues to rise and services continue to expand, both within existing community mental health teams (usually now called Recovery teams) and in specialist teams. Our experience is that women will often be given a diagnosis if they meet certain demographic criteria and are experiencing distress in certain ways, for example by self-harming, attempting suicide or making contact with emergency services and similarly the term Emerging Personality Disorder now seems ubiquitous for girls under 18 accessing CAMHS. For us as facilitators, both the diagnosis of BPD and the social context in which diagnoses take place; the oppressions which ‘cause’ the diagnoses, as it were, are as much issues of politics as mental health treatment and these beliefs altered the course of our delivery of the STEPPS group.

Rarely have we seen the ‘official’ criterion being used for or with people, but there is value in making reference to it here to place the work in context, and as the STEPPS programme makes use of it. For that reason we outline the DSM criteria, to which STEPPS explicitly refers rather than the World Health Organisation (WHO) International Classification of Diseases (ICD) guidance. BPD first appeared in the American Diagnostic and Statistical Manual (DSM) in 1980, in DSM III. The DSM is now on version 5 and states that for a diagnosis someone must have five or more from the following categories on a pervasive basis; frantic efforts to avoid real or imagined abandonment, a pattern of unstable and intense interpersonal relationships characterised by
alternation between extremes of idealisation and devaluation; marked and persistent unstable self-image or sense of self; impulsivity in at least two areas that are potentially self-damaging; recurrent suicidal behaviour, gestures, threats or self-harming behaviour; chronic feelings of emptiness; inappropriate, intense anger or difficulty controlling anger; transient stress-related paranoia or severe dissociation (DSM V). The STEPPS programme seeks to assess, measure and alleviate these ‘symptoms’.

**Policy and practice**

The policy context within the UK has long been mindful of the risk of people ‘falling through the net’, uncomfortably positioned within contemporary discourses as somewhere between ‘genuinely ill’ and exhibiting behaviours that they can control, with all the connotations of ‘deserving’ and ‘undeserving’ that this entails. Indeed, a pragmatic argument for specialist services is that it may reduce the damaging ways in which professionals often still talk about people given a diagnosis of BPD/EUPD, where phrases such as ‘manipulative’ and ‘attention-seeking’ are still disappointingly common. This is despite one of the first major documents addressing these issues, ‘Personality Disorder: No Longer a Diagnosis of Exclusion’ (NIMHE, 2003), being published well over 10 years ago, partially out of a recognition that often ‘people with a personality disorder are treated at the margins... on the caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them’ (NIMHE, 2003, p. 5). Similarly, the relationship between trauma and a BPD/EUPD diagnosis has also long been recognised, with the Department of Health’s mainstreaming gender and women’s mental health strategy (2002) recognising the over-representation of women given a diagnosis and the numbers of those who have experienced multiple instances of serious abuse and trauma’ (Department of Health, 2002).

Sex or gender specific services and support are often conspicuously absent in both policy rhetoric and in service provision, however; something we would again argue risks eliding both the value of women’s space in a patriarchal society and the impact of trauma and systemic violence against women. What is advocated instead are apparently
apolitical, de-gendered, individualised ‘evidence-based’ treatments which seek to alter the behaviours of those with the diagnosis, or rather, which claim to enable people to address their damaging behaviours. The UK National Institute for Health and Care Excellence (NICE) offers general guidelines and recommends potentially useful therapy frameworks, with the latter key ‘treatments’ being Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT), Cognitive Analytic Therapy (CAT), Schema Focussed Therapy and Transference Focussed Therapy, but states that more research is needed. It also identifies key areas for practice as collaborative working with the person and encouraging their active choices about care provision, fostering hopeful, trusting relationships, planning and managing endings carefully, using goal-setting, being clear about people’s roles and responsibilities (including the role of people such as the GP), developing crisis plans, limiting psychiatric drug use and providing psychological therapies only in a structured format, using an explicit and integrated theoretical approach, for 3 months or more and up to twice weekly (NICE, 2009).

The STEPPS programme, or Systems Training for Emotional Predictability and Problem Solving model is relatively new in the UK and not specifically mentioned by NIHCE, but it is growing in popularity and use. It was created in Iowa in the USA by Nancee Blum and colleagues (Blum et al, 2002; Black et al, 2004) and has subsequently been taken to other countries, including the UK, with the first groups started in Sussex Partnership NHS Mental Health Trust in 2007. It describes itself as a ‘cognitive-behavioural, skills training approach’, is rooted in Cognitive Behavioural Therapy (CBT) with aspects of DBT and schema therapy and states that its goal is ‘to provide the person with BPD, other professionals treating them and closely allied friends and family members with a common language to communicate clearly about the disorder and the skills used to manage it’ (STEPPS for BPD website). Its website summarises on its main page its key components as being ‘evidence based, group format, psychoeducational, manual driven, cognitive behavioural plus skills training, confronts early schemas (cognitive filters), systems approach’ and ‘includes support team’ (STEPPS for BPD website). Its facilitator manual states that ‘each group should be led by two leaders trained in group technique, cognitive therapy and treatment of BPD, who are experienced in working with clients with BPD, to allow for monitoring
and diffusion of transference’ (STEPPS Facilitator Manual). It is not marketed as a comprehensive model, but a ‘value-added’ intervention that augments existing care planning and is designed to be adaptable for a variety of settings, including prisons and primary care. It is rooted in a clear ‘reality’ of BPD as an ‘illness’, with no critical stance around the diagnosis, which is renamed Emotional Intensity Disorder (EID), although given its desire for adaptability to general settings, including young people’s and parent’s organisations, where the learning of its skills may still be helpful, a formal diagnosis is not essential for participation. It acknowledges the significance of stigma and negative perceptions of BPD and sees ‘reframing’ the ‘illness’ as important.

Service trends will depend on local priorities, demographics and staffing, but in our region of the UK where we were practising, DBT is by far the most common intervention used, with STEPPS groups also now emerging and some provision of MBT and CAT. This paper is not another evaluation of the STEPPS model and indeed our adherence to it was too loose for it to be so. Instead we seek to explore our experience of delivering the programme in the way that we did, making adaptations to a manualised programme along the way, arising from the group’s needs, service limitations and our own critical, feminist stance which challenged many of the assumptions implicit in both the programme and a BPD diagnosis.

The STEPPS model

The content of the STEPPS programme has been well-documented (Blum et al, 2002; Black et al, 2004). So too have evaluations of its use in several countries, including in the UK, using prescribed quantitative measures, the use of which is an essential, ongoing element of the programme (Van Wel, 2006; Harvey et al, 2010; Hill et al, 2016). It has also been evaluated in the range of contexts it has been specifically adapted for, where it has been used for specific groups with additional diagnoses and the impact its use has had on mental health staff (Shanks et al, 2011; Riemann et al, 2014). These evaluations have both positioned STEPPS as a viable alternative to existing treatments such as DBT or MBT and have argued for its ‘value-added’ benefits; that it ‘should not be seen as a stand-alone treatment’ but rather ‘embedded within an
overall treatment approach lasting longer than its duration’ (Harvey et al, 2010, p. 230). In a discussion about the ethical and methodological difficulties concerning the possibilities of evaluating STEPPS through a randomised controlled trial, the programme’s authors conclude that it may be said to be ‘effective in the UK’, based on research with the first groups that took place in Sussex, UK (Harvey et al, 2010, p. 231).

An understanding here of the core components and key themes of STEPPS is necessary however, to understand our adaptations to the group we ran and how our reflections sit alongside the existing evaluations of the programme. The prescribed group is a 20 session, closed group, with potential participants being assessed prior to joining the group. STEPPS may stand alone or precede STAIRWAYS1, its follow-on group which should run for a year, with sessions every fortnight and is designed around each of the 9 skills components of STEPPS, with each of these components running as a closed group (so there is more scope for participants to attend only the elements they feel they will benefit from). In what is perhaps an implicit recognition of the sex bias in diagnosis, if the group is to be a mixed-sex group, there should be at least 2 male group members. There are 3 key elements to STEPPS; initial ‘awareness of illness’ sessions, followed by 5 emotion management skills trainings and 8 behaviour management skills trainings. Awareness of illness involves an exploration of BPD and its reframing during the course as EID and provides space to identify individual difficulties and areas of change to focus on. It is largely supported by exercises about cognitive filters (rooted in schema therapy), with group members completing exercises to identify their strongest and weakest negative filters i.e lenses through which they view life. Negative filters include vulnerability to harm, abandonment, emotional deprivation and unrelenting standards. The emotion management skills sessions that follow and are to be used throughout the course are those of distancing: challenging; distracting; communicating and managing problems. Behaviour management skills in the course are setting goals, eating, sleeping, exercise, leisure, physical health, abuse avoidance and relationship behaviours.

STEPPS sessions should each last 2 hours, with a 15 minute break, and their content is highly structured, adhering strictly to facilitator and group member guidelines. Group members each have their own folder to keep their paperwork in and are expected to bring this to
group sessions and share it with their support network. In each person’s support network there is someone identified as a ‘reinforcer’, who has a responsibility to reinforce the elements of the programme and support with homework. There is a session for reinforcers and group members to attend together, early on in the programme but no structure for this, so we wrote something ourselves and held a ‘reinforcer evening’ in week 4. Although there are optional elements for specific times, such as Christmas, the ongoing format each week is roughly that of a revision session of the previous week’s topic prior to the break, followed by the introduction of a new topic after the break, which is then practised as homework between sessions. Weekly homework and the presentation of this to the whole group is a key element, fulfilling functions of both repetition and evaluation and indirectly potentially contributing to a sense of shared experience (though this is not made explicit within the course). The primary recurring forms to be completed and individual’s scores shared with the group are the Emotional Intensity Continuum (EIC), Skills Monitoring Card (SKC) and the Borderline Evaluation of Severity of Time (BEST). Group sessions are to have a specific atmosphere; ‘rather than following a traditional group therapy model, sessions have the look and feel of a class. Clients sit at a conference table facing a white board. Besides the use of the white board and the printed materials, the training is facilitated by poetry, audio recordings of songs, art activities and relaxation exercises’ (STEPPS Facilitator Manual).

**Setting up and running our group**

Several community team members undertook a 2 day training event focussed on the course content, facilitated by those involved in training people to be able to deliver STEPPS groups within the UK. After doing so, we set up a working group within secondary mental health services to consider the extensive practical issues involved in setting up a STEPPS group. These included promoting the group amongst the staff members and encouraging them to talk about it with service users; establishing a referral procedure; agreeing an assessment procedure and assessment timetable; considering the recurrent issue of people worrying about not having anyone in their informal network who could act as a ‘reinforcer’; agreeing case note recording processes and finding a
supervisor and scheduling supervision sessions for facilitators. Perhaps most significant of all was the emerging issue of the huge amount of administration associated with the group, which ranged from booking rooms to buying printing and photocopying materials and art supplies and sourcing refreshments with a very limited budget. No additional time was provided for facilitators, either for the extensive admin tasks, or for the running of the group. We conducted initial assessments in pairs, with people referred to us by staff members and we structured these around the Zanarini Rating Scale for BPD (Zanarini, 2003) used within STEPPS, a simpler questionnaire we devised with colleagues asking about the main difficulties they perceived themselves to have and a semi-structured interview asking about readiness to participate in a group more generally. We brought assessments back to the main working group then wrote to people to offer them a place or to suggest that it wasn’t suitable, copying in their care co-ordinator. Although we assessed men for the group, it soon became apparent that the group was going to be a women’s group. We offered places to 9 women, of whom 8 attended the first week and of whom 7 completed the whole programme.

We had originally planned to have 2 regular group facilitators and a rotating 3rd facilitator, thinking that it would be the best way of managing sickness and holiday absences, to ensure all staff who had received training had an opportunity to participate in the running of the group and to allow space for change, while still providing sufficient continuity to ‘hold’ the group. We very quickly realised that we needed to maintain a continuous 3 facilitators however, that is that we needed to be a closed group of facilitators. This sense emerged from anxieties expressed by group members about new people; from an unanticipated feeling that we were as much a part of the group as the group members; from an awareness of the complexity of the dynamics of the group and from a suspicion that altering the routine of the running of the group and explaining the practicalities to new facilitators would actually increase our already strained workload.

This realisation was perhaps the beginning of an ongoing sense of tension between both the manualised programme and what felt right (and possible) for us as facilitators running a specific group with a specific group of people, who had specific needs and expressed desires. This tension also relates to a broader one between the democratic,
feminist theory and beliefs underpinning our professional practice, and a model of working that assumes the validity of the psychiatric diagnosis of BPD and understands its ‘symptoms’ as always needing to be treated. We struggled openly with this throughout the programme. We therefore went through the manual together as facilitators and altered large sections of it so that we would spend longer on some exercises, leave others out and use materials that we wrote ourselves. We kept a log of notes and ideas and the group kept an ideas box, which they spontaneously contributed to throughout the weeks and together made a conscious decision early on to spend a greater proportion of time on grounding and relaxation exercises and craft activities. This decision was arrived at because group members found the course content exhausting, and because they were all wanting to make friendships within the group, as social isolation was something that they identified as problematic in their lives, and because allowing space to simply be together and practice doing something they found difficult (relaxing), felt valuable. This ‘groupness’, or shared space, either unacknowledged or deliberately challenged by the manualised programme, thus emerged as central to the delivery of our course early on.

This altered our take on the 3 main elements of the STEPPS programme, the changes to which we will briefly outline here. ‘Awareness of illness’ underpins the first few weeks of the manualised STEPPS programme. Some group members had a diagnosis of BPD, while others had different diagnoses and some of the women were unclear what diagnosis, if any, they had. This sense of a differentiation between what various doctors and other professionals had told them was wrong and the commonalities of their experiences on which the group was based, formed the basis of our introduction to a critical stance towards the diagnosis, which then framed the course. Several of the woman however, found the naming of their difficulties within an illness model helpful and important, and we did not detract from this, particularly given the cultural value of such labels and their significant and very real contingent relationship with economic and practical support, namely access to welfare benefits and support services. The ‘cognitive filters’ element of the course, which essentially reframes truths affecting how we see the world as biases, was emotionally draining, so we spent much longer on it and we positioned our critical stance towards BPD within this broader social constructionist framework.
We also sought to challenge the negative focus within the course and reposition a more balanced sense of all filters as being useful, or even essential survival strategies, at various points, dependent on the context in which they’re being applied.

The ‘emotion management’ skills of distancing, challenging, distracting, communicating and managing problems within STEPPS, follow on from ‘awareness of illness’ and are reinforced by constant repetition, at home and within the group and the various evaluation scoring charts mentioned previously. They theoretically underpin the skills needed for behaviour change in the next section of the course. We adhered to the fundamental ideas, but altered the delivery in ways that included spending time reading written content aloud as facilitators and group members (skipping turns where people didn’t feel confident doing this), sharing examples of implementing skills between sessions, group ideas-sharing, undertaking exercises as a whole group (using real and invented examples from both group members and facilitators), taking turns to lead mindfulness activities and using art activities as a means of developing skills such as distraction. Evaluation scoring sheets and homework soon proved to be emotionally and practically difficult for most group members, with additional stress caused by the sharing of these when some people had managed it and others hadn’t. Given the ongoing difficulties with people’s reinforcers and several group members being reliant on busy professionals acting as their reinforcer, and the likelihood that we would lose group members if we didn’t continue to make changes, we made a deliberate decision to move away from such an explicit focus on these aspects of the manualised programme and replaced them as described above. The changes also enabled us to be more inclusive and accommodating of people’s needs, since several group members struggled with the volume of paperwork for various practical reasons related to (lack of) time, dyslexia and literacy issues.

Changes to the structure of the sessions continued for the ‘behaviour management’ skills sessions, concerning setting goals, eating, sleeping, exercise, leisure, physical health, abuse avoidance and relationship behaviours that follow according to the manual, though we moved even further away from the given written materials here, often replacing them with our own. We were also led more by the group than the manual, (and by now with an increased confidence in doing so), as to how much
time was spent on each topic and what should be done as a group or as homework. This was in part out of a recognition that it was simply doing the women a disservice to cover in two hours, aspects of their life that for some of them had been problematic for decades, (mostly eating and sleeping). We were also explicit in placing all of these issues within what we understand to be a social context of patriarchal oppression, through which all women's relationship with their bodies, and thus issues of eating, health and exercise, are seen as inherently problematic and a source of guilt and shame. In this way we sought to challenge the individualisation of both problems and filters, relating them to broader social concerns affecting everyone.

Relatedly, difficulties in all these areas for all the women in the group, had some connection to trauma and male violence, as it does for most women given a BPD diagnosis; the two cannot be separated (Proctor and Shaw, 2005). A politicised awareness of this was for us as important as individualised behavioural tools for change, but also a means of effecting change. So we explored for example, the social sanctioning of women's disordered eating patterns in the form of endless diets and the subtle and often not-so-subtle cultural positioning of women as being responsible for their own abuse, particularly sexual abuse. We also discussed ideas around victim-blaming, at the same time as giving details of support organisations. The classic feminist mantra of ‘the personal is political’ underpinned these sessions, and we were reminded of the women’s consciousness raising groups that formed a cornerstone of the second wave of the women’s liberation movement. They strayed far from the STEPPS manual, but sessions in which women spontaneously shared their own experiences of violence and abuse were undoubtedly some of the most pivotal and powerful moments of the course. At the end of the course we also held a party and spent time within the group planning and preparing for this; this too was a real celebration and was as much about the women themselves and the relationships they had formed during the group, as it was a recognition of the work completed and the conclusion of the first STEPPS group locally.
Evaluations and reflections

The group’s retention rate over a 20 week period, with only one woman dropping out and doing so in the first week, is one means of measuring the success of the group. This may be compared with voluntary groups in mental health services more generally and with the STEPPS group in the UK. It also needs to be placed in the context of a group heavily adapted from a manualised programme and an honest acknowledgement that had we not made these changes, and more specifically had we not adopted the ‘take it or leave it’ approach that we did towards homework and the evaluation scoring sheets, it is likely that we would have lost several group members. A choice was therefore made about whether group attendance in itself, or faithfulness to the manualised programme was more important and we chose the former. We did undertake evaluations throughout the course however and these took the form of semi-structured written feedback at the midpoint and endpoint of the course; one to one reviews with individuals, their care co-ordinator, reinforcer and anyone else they wanted to attend after the course had ended; ad hoc review sessions of a similar nature during the course where issues were emerging; a group evaluation session towards the end of the course and a follow-up group revision and evaluation session 2 months after the official end of the course. Some group members also found the completion of the various individual scoring forms, the BEST, EIC and SKC, upon which existing STEPPS evaluation data is based (Blum, 2002; Black, 2004), to be helpful in monitoring their own progress.

General feedback from the group highlighted both practical and emotional advantages and disadvantages to undertaking the course, and their comments and ours were passed on to other potential facilitators within the wider team and taken to other development forums within the mental health trust. This sense of service development was important to all of the women within the group and they felt proud of being the first group to complete the course and as such, support our development as facilitators and establish a future for the group. Negative feedback was received from group members about the amount of paperwork involved (even after we reduced it significantly); paperwork being difficult to understand; tensions between group members that were at times uncomfortable and didn’t always feel safe; the group
taking place on Fridays with no support in place over the weekend and the group at times becoming distracted and straying off topic. Positive feedback was received about the achievement of finishing the course; friendships made during the course; confidence gained on the course; shared ideas that have worked for other people; the knowledge that other people experience similar difficulties; the structure of the course; repetition of skills and the shared commitment of group members. Women also commented that other people had started to notice changes in the way that they coped with life, with one woman giving written feedback that her life now was almost unrecognisable to the one she had before the group started. She went on to say that she had grown up believing that what other people said to her was true and to start challenging this had been a complete revelation.

To summarise our main thoughts about issues relating to the group and the service context in which it was delivered, we would have held an introductory session prior to the start of the group, outlining the course content and forms and allowing people to start getting to know each other; we would advocate strongly for single-sex groups and we would continue to reduce much of the paperwork involved, as we became particularly mindful of how difficult this was especially for people with poor school experiences and for people with dyslexia. We would also aim to be part of a wider network of people facilitating courses elsewhere; consider follow-on provision, either in the form of STAIRWAYS or a more informal group, prior to the start of the course, as the absence of this was felt as a real lack by group members and we would clarify the role of reinforcers and how they may best function alongside professional support workers in people’s care team. Similarly, were we running such a group again it would have helped to have had better links across services, so that community and crisis team workers could relate their responses to a knowledge of the work being undertaken in the group. These latter issues largely relate to service provision and we were disheartened that despite such positive feedback, another STEPPS group did not run locally for several years and nor did any other groups such as STAIRWAYS, (though our group members continued to meet informally at a local coffee shop). This raises particular concerns about messages sent out to service users about the value placed on certain aspects of care and indeed about the contradiction between asking that they set goals and make huge
changes, while services don’t do the same. More worryingly, this apparent inertia may relate to broader service and policy desires to make services more time-limited and outcomes driven and a pressure to get people out of services and into work (Department for Work and Pensions, 2015). At the same time, there are real issues about how services or groups that are genuinely service user led or facilitated, in a way that we would like STEPPS to become, sit within a broader community mental health service context that is largely paternalistic and diagnostically driven.

Discussion

Groupwork is a natural fit for women who have a diagnosis of BPD. Similarly, it is a good fit for women without a diagnosis but with perceived issues with ‘emotional dysregulation’, where similar critiques about how emotion and its expression is problematically defined according to gendered and cultural norms (Busfield, 1989). We would argue however, that this groupwork fit largely arises from its potential to be liberatory in a way that individual interventions and therapies do not. In this way, groups of people can normalise shared experiences, promote an equal sharing of ideas for support, break cultural silences that enable abuse to happen, create space for political analysis of issues affecting individuals and foster friendships among people who are often incredibly isolated. They are also a way of providing practical support for people whose daily lives are impaired by the consequences of trauma, both through taught content and these potential friendships. Perhaps most importantly, they can move beyond political critique to activism seeking social change and it is undeniably from our perspective, social change addressing structural inequalities that would reduce the social problems that come under the umbrella of BPD, both in terms of its ‘causes’ and its consequences.

A manualised, skills-based programme such as STEPPS risks reinforcing ideas about responses to trauma as illness and depoliticising the epidemic of physical and sexual violence against women by reducing it to an issue of individual behaviour management from the person who was abused. We would level similar criticisms of other group programmes such as DBT and suggest that there are real risks associated
Groupwork is a highly skilled task and as some of the service user comments noted, we did at times struggle with the dynamics of the group. Perceived slights, shifting alliances and varying levels of dominance within the group proved difficult to manage at times over the 20 weeks that the course ran, despite our experience in both running groups and working in mental health services. We met with individuals as needed and tried to let the group resolve issues themselves as far as possible, but we did also impose some structure through group-approved rules such as placing time limits on the sharing of homework, setting a weekly agenda with time frames and writing it on a board so that group members could hold each other to account, by reminding each other of the agenda and asking people to put their hands up before speaking. There is somewhat of an irony about the tension between the challenges of running a group concerned with emotion regulation and the lack of reference to the expression of emotions in a manualised programme that places such an emphasis on skills, though this issue does not seem to be unique to STEPPS by any means. Our experience was that the necessarily more emotionally involved groupwork elements became unavoidable and we would suggest that a balance may be struck between a more therapeutic space and a structured environment, that best facilitates the learning or teaching of fixed techniques which may help people in their daily lives. We would argue that despite some of the difficulties we encountered in running the group, this balance lies in harnessing, rather than quashing the ‘groupness’ of a group. Indeed, that there is an inherent value in creating safe spaces for women (and other marginalised groups) to share their experiences together, as a simultaneously political and therapeutic act, and that this may be the starting point for change.
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**Note**

1. STAIRWAYS is an acronym for Setting goals; Trying new things; Anger management; Impulsivity control; Relationship management; Writing a script; Assertiveness training; Your choices and Staying on track.

**References**


Small STEPPS: The provision of, and changes to, an emotional regulation group for women


