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INVESTIGATING THE EFFECTIVENESS OF EMOTION REGULATION SKILLS GROUPS AND SERVICE USER PERSPECTIVES

Section A:

A systematic review of emotion regulation skills interventions in group settings for people with borderline personality disorder

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Summary of Major Research Project

Section A: This is a systematic review of the evidence base of the effectiveness of emotion regulation skills groups for people with BPD and processes that facilitate change. It also looks at the service settings where these groups are used and the service user perspective. A systematic search using eletronic databases identified 17 papers relating to emotion regulation skills groups. There were no qualitative studies looking at the service user perspectives when taking part in these groups. The evidence base demonstrates that emotion regulation skills groups are effective in increasing emotion regulation. Limitations and future research implications are discussed.

Section B: People who have difficulties with regulating emotions and a subthreshold diagnosis of BPD experience intense emotions. This leads to difficulties in managing relationships and chaotic environments within group interventions. This study explores service user perspectives on taking part in an emotion regulation skills group (STEPPS-EI) including relationships within the group, the groups' meaning to the participants and impact on existing relationships. A qualitative approach using interpretative phenomenological analysis (IPA) was utilised. There were three superordinate themes: An emotional journey, developing group relationships and developing and understanding self. The limitations, clinical implications and research implications are discussed.

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SECTION A: A Literature Review

A systematic review of emotion regulation skills interventions in group settings for people with borderline personality disorder

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Abstract

Introduction

Recent systematic reviews show a benefit of delivering group interventions for people with a diagnosis of BPD. This review focuses on the evidence base for emotion regulation skills groups for people with BPD across different treatment modalities including DBT skills groups, STEPPS and ERGT. It explores the service settings where the group interventions were found to be effective and service user perspectives regarding these interventions.

Method

A systematic search using electronic databases was carried out to identify research investigating the effectiveness of emotion regulation skills group interventions. Research providing individual therapeutic interventions alongside group interventions was excluded.

Results

A total of 16 papers were identified and critically reviewed. Of these 11 had a quality rating of moderate or strong. The emotion regulation skills groups were mostly provided in community mental health care settings, with three studies carried out in prison and inpatient settings. There was no research exploring the views and experiences of service users.

Conclusion

The reviewed studies suggest emotion regulation skills groups, including DBT, STEPPS and ERGT, are effective in supporting people with BPD to manage emotion regulation. The review of the factors that mediate change indicated the improvements are facilitated by teaching people to cope with intense emotions and improved emotion regulation.

Key words: Borderline personality disorder, emotion dysregulation, emotion regulation skills group, mediating and moderating factors, systematic review.

Introduction

Borderline Personality Disorder

Borderline Personality disorder (BPD) is a psychiatric diagnosis describing people who experience a range of difficulties with instability in interpersonal relationships, emotion dysregulation, difficulties with self-image, as well as markedly impulsive behaviour (American Psychiatric Association (APA), 2013). In particular, their experience of intense and rapidly changing emotions leads to difficulties managing and maintaining stable interpersonal relationships, which results in high levels of distress and often recurrent suicidal behaviour. The prevalence of BPD ranges from 11% to 42.7% within psychiatric populations (Zimmerman, Rothschild & Chelminski, 2005) and people often experience additional impulsive problems such as substance dependence, eating disorders and suicidality (Paris, 2018). The development of BPD is thought to be linked to attachment difficulties in childhood, with risk factors such as trauma in early life and problematic parenting (Keinänen, Johnson, Richards, & Courtney, 2012). Multiple difficulties experienced by people diagnosed with BPD have been linked to emotion dysregulation (Linehan, 1993). This is not an absence of regulation, but the way in which the individuals regulate their emotions result in an impairment or restriction of functioning (Cole, Michel & Teti, 1994; Linehan, 1993).

BPD as a diagnosis

The validity of personality disorders as a diagnosis has been controversial due to a lack of a coherent understanding of the aetiology and critical processes underlying the development of the disorders (Livesley, 2018). The DSM-V and the International Classification of Disease-10 (ICD-10) are diagnostic manuals used for diagnosis of mental health problems (APA, 2013; World Health Organization [WHO], 1992). The ICD was developed by the WHO whereas the DSM was developed by the US Public Health Service to support clinicians in identifying mental health conditions. However, their development was not co-ordinated resulting in

different labels for BPD (BPD and Emotionally Unstable Personality Disorder- Borderline [EUPD]), although their criteria are now broadly comparable (Livesley, 2018). The diagnosis of BPD was previously linked to exclusion from treatment options as professionals believed they did not have the required skills or training to offer appropriate interventions (National Institute for Mental Health in England, 2003). The diagnosis continues to be linked to increased stigmatisation from health care professionals (Knaak, Szeto, Fitch, Modgill, & Patten, 2015).

The diagnostic systems suggest there is a cut-off point for BPD where certain symptoms become a disorder with "a boundary between the normal and sick" (APA, 2013; Livesley, 2018, p. 8; WHO, 1992). However, presence of impairment within nonclinical populations suggest BPD is better conceptualised dimensionally in terms of severity. Within nonclinical populations, difficulties regulating emotions are linked to poorer academic, interpersonal and emotional outcomes (Trull, Useda Conforti & Doan, 1997), which is consistent with the main features of emotion dysregulation in BPD (Linehan, 1993). There have been movements toward development of dimensional trait models, but this task is proving difficult due to a lack of consensus within the field (Livesley, 2018). Researchers have used the term 'subthreshold diagnosis of BPD' when participants meet several criteria for BPD, but not the required five criteria, in order to bridge the gap that exists without a dimensional model (Gratz & Gunderson, 2006; Ramleth, Groholt, Diep, Walby, & Mehlum, 2017).

Another problem has been a gender bias where women are more likely to receive a diagnosis of BPD than men, despite an equal presence within the general population (Grant et al., 2008). These gender differences appear to be in the presentation of symptoms, which may result in a greater number of men accessing substance misuse services and women mental health services for self-harm (Sansome & Sansome, 2011). These limitations are important to

consider within clinical settings where the boundaries of diagnosis and the gender bias may lead to commissioning of services that do not meet people's needs.

The diagnosis of BPD has been controversial; however, it can be helpful in identifying a group of people who have difficulties with emotion regulation and interpersonal relationships although it is important to recognise the problems and limitations.

Service utilisation

Some of the recurrent problems in people with a diagnosis of BPD are suicidal behaviours and deliberate self-harm (DSH) leading to a high use of accident and emergency (A&E) departments. These behaviours are often linked to disappointment in interpersonal relationships (Paris, 1996). People with BPD have a high level of service utilisation receiving more psychotherapy, medication consultation, A&E visits and inpatient hospitalisation compared to those with major depressive disorder (Bender et al., 2006). They also have more inpatient stays than those who experience other diagnosed personality disorders (Zanarini, Frankenberg, Khera & Bleichmar, 2001). This means investing in effective interventions for BPD not only improves people's well-being but has the potential for saving public funds.

Interventions for BPD

The NICE guidelines for BPD advise that symptoms should not be managed using medication, although it can be used for co-morbid conditions (National Institute for Health and Care Excellence (NICE), 2009). Black, Allen, McCormick, and Blum (2011) found no relationship between clinical severity and the level of drug treatments people with BPD received, which indicates that medication is at times prescribed without sufficient rationale. The evidence base suggests drug treatments are not effective in managing symptoms, or supporting people into recovery, making alternative interventions even more critical.

A number of manualised individual psychological therapies have emerged for BPD (Zanarini, 2009). These include Mentalization Based Therapy (MBT; Bateman & Fonagy, 2004), Transference Focused Psychotherapy (Kernberg, Selzer, Koeningsberg, Carr & Appelbaum, 1989), Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Schema Therapy (Young, Klosko, & Weishaar, 2003). The NICE guidelines (2009) for BPD suggest brief psychological interventions of less than three months should not be used, and for women with DSH the DBT programme is recommended.

The benefit of groups

Recent systematic reviews show a benefit in delivering group interventions for this population over individual psychotherapy (Omar, Tejerina-Arreal & Crawford, 2014; Stoffers-Winterling et al., 2012). There are a number of therapeutic benefits within group settings which include the installation of hope, universality of difficulties, sharing of information, group cohesiveness, existential factors and family re-enactment among others (Vinogrador & Yalom, 1989). These factors are considered helpful for people with a range of mental health difficulties including panic disorder (Behenck, Wesner, Finkler, & Heldt, 2017), psychosis (Restek-Petrović et al., 2004) and social phobia (Choi & Park, 2006). Several individual psychotherapies for BPD now include manuals for psychotherapeutic groups, which is resulting in a growing evidence base for group based interventions that are diverse in focus. MBT for groups is based on the notion that BPD symptoms are associated with a failure in mentalizing within interpersonal relationships (Bateman & Fonagy, 2004; Fonagy & Bateman, 2006) whereas Schema-Focused Group Therapy addresses the individual's maladaptive schemas which are persistent patterns of thinking, feeling and interacting with others (Arntz & van Genderen, 2009; Kellogg & Young, 2006). DBT skills groups (DBT; Linehan 1993), Systems Training for Emotional Predictability and Problem Solving (STEPPS; Black, Blum, Pfohl & St. John, 2004) and Emotion Regulation Group

Treatment (ERGT; Gratz & Gunderson, 2006) are interventions with a focus on developing the individual's coping skills to address emotion dysregulation.

Interventions within mental health services

The NICE guidelines suggest interventions for BPD should be of 3 months or more which is reflected in the intensive therapeutic interventions, such as DBT, Schema Therapy and MBT where the enduring difficulties in interpersonal relationships are addressed (Linehan, 1993; Young et al., 2003). However, Zanarini (2009) argues DBT and MBT interventions are difficult to implement in mental health services and therefore not accessible to many communities. Therefore, it is essential to identify effective interventions that are suitable for delivery in mental health settings. Emotion regulation skills-based group interventions such as STEPPS and ERGT are arguably easier to implement alongside support from ongoing care delivery as they are shorter and less intensive. However, the effectiveness of these groups needs to be established, including the types of settings for which there is an evidence base. There is an ongoing debate and differing views of what is needed in order to achieve change for people with BPD. Greenberg and Safran (1987) suggest emotional patterns need to be experienced within interventions in order to increase emotion regulation. However, processes that lead to change within group settings need to be established as it is unclear whether these are equivalent and there are a variety of approaches available. Furthermore, the views of service users who have participated in skills-based groups need to be explored to ensure these interventions are appropriate.

Focus for this review

The focus of this systematic review is to look at the evidence base for emotion regulation skills groups for people with BPD across different treatment modalities, as emotion dysregulation is the focus of several different group interventions. This will include processes

that have been identified in facilitating change within these therapeutic groups. The review will also explore the types of services where skills-based groups have been found to be effective and the perspectives of service users in relation to this form of therapeutic intervention.

Methodology

Search method and selection of studies

A systematic search was carried out using electronic databases. Two searches were carried out in PsychInfo, Medline, Cochrane database of systematic reviews and Web of Science Electronic using the following terms: 'borderline personality disorder'/ 'emotionally unstable personality disorder' AND ('group therap'* OR 'group intervention*' OR 'group psychotherap*' OR 'group psychoeducation*'); and also 'borderline personality disorder'/ 'emotionally unstable personality disorder' AND 'psychoeducation'. The titles and abstracts were reviewed to identify which records met the review criteria. References of the relevant papers were hand searched. The searches yielded a result of 16 research studies to be included in the review (see Figure 1.).

Criteria for considering studies for this review

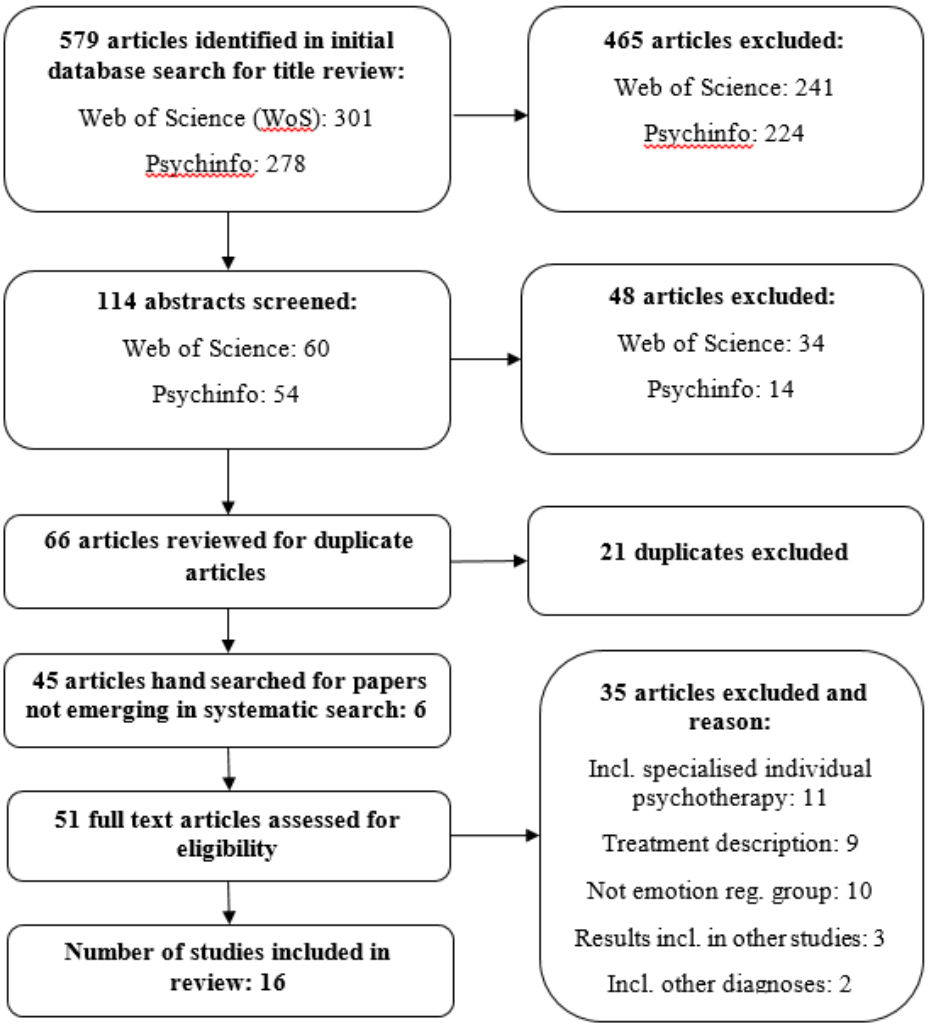
The criteria for inclusion in this review were research studies investigating the efficacy of interventions delivering emotion regulation skills teaching within group settings for people experiencing BPD. Research studies were included if they investigated the effectiveness of emotion regulation skills group interventions, the processes that facilitate change or the experiences and views of those who have taken part in these types of interventions. Only studies examining interventions described as emotion regulation skills teaching that avoided a focus on individual difficulties and experiential work, were considered for this review. This meant that groups such as Schema-Based Group Therapy and Mentalization-based Group

Therapy with a focus on experiential strategies or interpretation of defences to enhance corrective emotional learning were excluded (Jørgensen et al., 2013; Wetzelaer et al. 2014). Studies were included when they had at least one emotion regulation skills group intervention that was stand-alone or delivered alongside treatment as usual. Studies were excluded when all the emotion regulation skills groups included a specialist individual psychotherapy to enhance the learning from the group treatment.

The studies included were with adults (18 and above) who met the diagnostic criteria for BPD or with a subthreshold BPD diagnosis. Participants were considered to have a diagnosis of subthreshold BPD when they fell just below the cut-off point for a full diagnosis, that is, meeting three out of the required five criteria for a full diagnosis. Studies were excluded when the focus was on other mental health difficulties than BPD, interventions for couples or carers, or when the data from research was already published within other research studies.

Figure. 1.

Flow of search and selection of peer-reviewed articles.



Method for systematic review

Each of the retrieved studies which investigated the efficacy of emotion regulation skills groups were evaluated using a quality rating system by the Effective Public Health Project (see appendix A; Thomas, Ciliska, Dobbins, & Micucci, 2004). This tool assesses a study's individual components, including selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop-outs, in order to achieve a global rating. It has a three point rating scale which is applied to each individual component (weak, moderate and strong). A study without any weak components receives a strong global rating, those with one

weak component a moderate global rating and a study with two or more weak component ratings is deemed weak in its global rating. This tool can be applied to a range of research designs and has demonstrated reliability and validity (Thomas et al., 2004). Please see Table 1. for the individual component ratings and global rating for each study included in the review below.

Table 1.
Individual component rating and global ratings for studies included in review

STUDY RATING	STUDY DESIGN	SELECTION BIAS	CONFOUNDING VARIABLES	BLINDING	DATA COLLECTION METHODS	WITHDRAWALS	GLOBAL STUDY QUALITY
BLACK ET AL. (2013)	Moderate	Moderate	Weak	Moderate	Strong	Weak	**Weak**
BLUM ET AL. (2002)	Moderate	Weak	Weak	Moderate	Strong	Weak	**Weak**
BLUM ET AL. (2008)	Strong	Moderate	Strong	Weak	Strong	Moderate	**Moderate**
GRATZ & GUNDERSON (2006)	Strong	Moderate	Strong	Weak	Strong	Strong	**Moderate**
GRATZ & TULL (2011)	Moderate	Moderate	Weak	Weak	Strong	Strong	**Weak**
GRATZ, TULL & LEVY (2014)	Strong	Moderate	Strong	Moderate	Strong	Moderate	**Strong**
LINEHAN ET AL. (2015)	Strong	Moderate	Strong	Strong	Strong	Weak	**Moderate**
MCMAIN ET AL. (2017)	Strong	Strong	Moderate	Moderate	Strong	Moderate	**Strong**
MORTON ET AL (2012)	Strong	Strong	Moderate	Moderate	Strong	Moderate	**Strong**
SAHLIN ET AL. (2017)	Moderate	Moderate	Moderate	Weak	Strong	Moderate	**Moderate**
SHILLING ET AL. (2015)	Strong	Moderate	Strong	Moderate	Weak	Weak	**Weak**
SHILLING ET AL. (2018)	Strong	Strong	Moderate	Moderate	Strong	Moderate	**Strong**
SOLER ET AL (2009)	Strong	Moderate	Strong	Strong	Strong	Weak	**Moderate**
WILLIAM, HARTSTONE & DENSON (2010)	Strong	Strong	Strong	Moderate	Strong	Weak	**Moderate**

The Efficacy of Emotion Regulation Skills Groups for BPD

The current review identified 14 research studies that investigated the efficacy of emotion regulation skills groups that met the search criteria. These included three established emotion regulation skills group interventions which were Emotion Regulation Group Treatment (ERGT), Dialectical Behaviour Therapy (DBT) and Skills Teaching for Emotional Predictability and Problem Solving (STEPPS) groups. There were two further studies looking at metacognitive training for people with BPD (BMCT) and a stand-alone Acceptance and Commitment Therapy group. The quality of each research study is critically evaluated below (see appendix B for a detailed summary of the key components including statistical data).

Systems Training for Emotional Predictability and Problem Solving (STEPPS) group

An initial pilot study by Blum, Pfohl, St. John, Monahan and Black (2002) used a mixed design to explore the effectiveness and acceptability of a 20-week STEPPS programme utilising a cohort design (n=52) and a survey design (n=49). The study appears to lack rigour in the selection process where 49 women and three men meeting DSM-IV criteria for BPD were recruited but a formal assessment process was not reported, neither was the recruitment process or inclusion criteria. Therefore, it is impossible to ascertain whether participants represent a population with a diagnosis of BPD seen in mental health settings. The outcome of the study may have been inflated as a range of issues were not addressed within the study design and the data analysis did not consider confounding variables, participant withdrawals or an intention-to-treat (ITT) analysis. The outcome measures were based on routine outcome measures collected within the services at baseline, during and post- intervention, but would have benefitted from an additional follow-up as well as a clinician administered measure of change in BPD symptoms. The authors report a statistically significant decrease in depression symptoms and a decrease in BPD negative behaviours although there were no statistically significant differences in BPD positive behaviours or negative thoughts and feelings. A

survey was compiled to gather information about the therapists' and participants' experiences, which indicated that participants felt more skilled in managing their emotional states and therapists found the programme easy to use. While this provided helpful information at an initial stage of the development of a new therapy, the measures used were not standardised and may therefore lack validity. There are a number of limitations in this research study due to confounding variables not being considered, the lack of inclusion criteria and level of drop-out from the study not being reported resulting in a weak global quality rating.

Blum and colleagues (2008) investigated the effectiveness of a 20-week STEPPS programme alongside treatment as usual (STEPPS-TAU; n=65) as opposed to treatment as usual alone (TAU; n=59) in a randomised controlled trial (RCT). TAU included medication and individual psychotherapy which were adequately addressed as confounding variables together with demographics and pre-intervention outcome measure scores. Recruitment was carried out in inpatient and outpatient mental health services through advertisement and word of mouth with 165 people recruited that met DSM-IV criteria for BPD. However, 40 people did not commence treatment, which led to a total of 103 female and 21 male participants taking part. Despite attempts to keep assessors blind to treatment conditions this was not maintained and is a weakness within this study resulting in a global study quality rating of moderate. Outcome measures were regularly gathered during, as well as following the 20-week intervention up until 12 months post-treatment. The STEPPS intervention had good treatment consistency and ITT principles were followed within the analysis; however, the 40 participants that did not commence the study should have been included to meet the requirement for an ITT analysis. Participants in the STEPPS-TAU group showed significant improvements in BPD symptoms and depression symptoms with rates of change greater than

the TAU alone group and treatment gains were maintained at follow-up. There was also a statistically significant greater use of A&E services at follow-up for participants in the TAU condition. This study demonstrates the potential effectiveness of the STEPPS intervention through use of outcome measures and service data, although the lack of an active control condition means other factors such as increased support could account for the improvements.

Black, Blum, McCormick and Allen (2013) investigated the efficacy of a 20-week STEPPS programme (n=77) within prison settings using a pre-, mid and post- intervention cohort design. There were 67 participants enrolled from a prison setting and 10 from a community corrections-based setting. The participants had to meet DSM-IV criteria for BPD diagnosis. However, the use of a formal assessment measure was not reported and it is therefore unclear whether this sample represents a population with a BPD diagnosis. Demographic, social and clinical features were reported for the 63 female and 14 male participants but the study did not control for any potential confounding variables, which leads to a weak individual component rating for this area. There was a high level of drop out with a total of 47% participants who did not complete the STEPPS programme, which is an additional weakness for this study. The prison setting had 39% of participants drop out entirely due to transfers and the community based setting had 100% drop out. The drop-out rate within the community setting raises some concerns regarding the suitability of the programme for this type of setting. The data analysis showed statistically significant improvement in BPD symptoms and depression symptoms along with statistically significant improvements in suicidal behaviours and disciplinary infractions. This demonstrates a potential benefit of accessing STEPPS within a prison setting. However, limitations in the management of confounding variables and the high drop-out rate may lead to inflated results and therefore the overall study is rated as weak in the global quality rating.

Emotion Regulation Group Therapy (ERGT)

Gratz and Gunderson (2006), the developers of a 14-week ERGT, used an RCT to explore the effectiveness of ERGT combined with TAU (n=12) versus TAU alone (n=10) with data collected pre- and post-intervention. This small-scale study recruited 22 women meeting the criteria for a DSM-IV diagnosis of BPD through referrals from clinicians in a hospital, private practice and advertisements. There were multiple inclusion criteria relating to self-harm and gender and this may exclude some people who represent the population usually seen in mental health services. The authors accounted for a range of confounding variables which is a strength. While the study was reported as randomized, there was no blinding in place which is a weakness as this may lead to observer bias. Therefore the global study quality is rated as moderate. Data analysis showed statistically significant improvements in emotion dysregulation, depression, anxiety and BPD for participants in the ERGT. An analysis of clinical significance showed participants with reliable improvements and symptoms for depression (50%), anxiety (33%) and stress (67%) within a normative range. The authors also reported that 42% of participants in the treatment condition showed a 75% reduction in self-harm. However, this study did not include a post-intervention follow-up and therefore does not demonstrate whether improvements are maintained over time. ITT analysis was not completed but the small drop-out rate of 8% means the results would only be marginally inflated. The study has a number of strengths and the results supports the efficacy of ERGT. The newly developed intervention was delivered by the authors who developed ERGT and therefore efficacy needs to be demonstrated by other therapists.

An uncontrolled cohort research design was used by Gratz and Tull (2011) to explore the effectiveness of a 14-week ERGT (n=23) with a more diverse sample than in the initial RCT by Gratz & Gunderson (2006). Participants were recruited through referrals from clinicians

and advertisement. They were required to be female, meet four criteria of five needed for a BPD diagnosis, experience deliberate self-harm and have an individual mental health practitioner. There were limitations in some individual component ratings of the study with uncontrolled confounding variables and assessors not blinded to conditions due to this being a cohort design. This resulted in the study receiving a weak global quality rating. Data was collected one week prior, and one week post group intervention, but without follow-up data it is unclear whether any benefits of the intervention were sustained over time. There was a low drop-out rate of 17.4% from ERGT. There were statistically significant changes over time for the group completer sample including BPD symptoms, emotion dysregulation, depression and anxiety, all with large effect sizes. Clinical significance was analysed and a number of participants reached normative levels of functioning and reliable change for emotion dysregulation (57.9%), BPD symptoms (42.1%), depression (21.1%) and anxiety (10.5%). The analysis of an ITT sample was highly consistent with the completer sample, apart from anxiety which did not reach statistical significance. The study had a thorough analysis of outcome measures; however, the lack of controlling for confounding variables means other factors than ERGT could account for improvements.

An RCT trial by Gratz, Tull and Levy (2014) investigated the effectiveness of ERGT alongside TAU (n=31) compared to a TAU waitlist control group (n=30) and included a nine-month uncontrolled follow-up (n=51). Recruitment to the study was through clinician-referrals, advertisement and self-referrals. Participants were required to meet diagnosis or a subthreshold diagnosis of BPD according to DSM-IV. However, the authors failed to clarify how they differentiated this but refer to evidence that meeting three or more criteria of BPD diagnosis is clinically important (Clifton & Pilkonis, 2007). They reported that 88.5% met the full criteria for a BPD diagnosis. ERGT was particularly developed for people with DSH and

all participants had a history of this and were under the treatment of a psychotherapist, psychiatrist or other mental health professional. A strength within this RCT was that a range of confounding variables were controlled or considered in the study design, including symptoms severity, age and amount of psychotherapy. The trial also had an acceptable level of participant drop-out of 23.5%. Assessors were blind to the treatment conditions, which is a strength in the study design. Data analysis was completed using an ITT sample which demonstrated significant effects of ERGT on emotion dysregulation, BPD symptoms, depression and anxiety. Clinical significance was analysed with 41.9% showing clinically significant improvement in BPD symptoms and 35.5% in DSH following the ERGT; as well as 49% of participants within ERGT having clinically significant improvements in BPD symptoms and 43.1% in DSH at a 9-month follow-up. The global quality rating was strong and the study demonstrated the effectiveness of ERGT in reducing BPD symptoms. The main limitation was the lack of an active control group as other factors such as universal group factors or increased contact with professionals could contribute to the positive findings.

Sahlin and colleagues (2017) carried out an uncontrolled open trial using a cohort design with a six-month follow-up to investigate the effectiveness of a 14-week ERGT. A female only sample was recruited and 95 women with a diagnosis of BPD who experienced DSH took part. Several confounding variables were controlled for; however, the lack of a control group means the improvements could be accounted for by increased contact with healthcare professionals and benefits of being a part of a group. There was a risk of researcher and participant bias in reporting of results as this study was not blind, which represents a limitation leading to the overall study receiving a moderate quality rating. Data was collected at baseline using self-report measures completed online and maintained an acceptable level of participants with 22% not completing the study. Analyses completed on an ITT sample

showed a 76% reduction in DSH from pre-treatment to the 6-month follow-up with a large effect size and for BPD symptoms a 35% reduction was observed. There were statistically significant improvements for emotion dysregulation, depression and anxiety symptoms; however, the improvement in anxiety is debateable considering the confidence interval ranged from 0.01 to 0.49. This study demonstrated ERGT was effective in reducing BPD symptoms and DSH in women within a clinical population, but the lack of an active control group means the effectiveness could be due to other variables.

Dialectical Behaviour Therapy (DBT) skills group

Soler and colleagues (2009) carried out a randomized single-blind clinical trial exploring the effectiveness of a 13-week DBT skills group (DBT-SG; n=29) compared with a standard group therapy (SGT; n=30) based on psychodynamic principles. The 49 female and 10 male participants had a DSM-IV diagnosis of BPD and were recruited from community mental health settings and accident and emergency (A&E) departments. During the trial all participants were reviewed every two weeks by the psychiatrists, which was an additional treatment to the allocated interventions. A number of confounding variables were accounted for, including ensuring participants did not change medication during the intervention representing a strength within this study. The study's drop-out component was rated as weak with 49% of participants not completing their allocated intervention which led to the study receiving a moderate global quality rating. DBT-SG had a higher retention rate (65.5%) than SGT (36.6%), which is important as the drop-out rate is known to be high within this population. This was appropriately adjusted for by utilising an intention-to-treat (ITT) sample for the data analysis. Assessment and outcome measures were collected by two psychiatrists blind to conditions before group allocation and after the intervention. The analyses showed participants in DBT-SG had greater improvement in depression and anxiety than SGT. Statistically significant improvements were observed for both DBT-SG and SGT in BPD

symptoms, demonstrating they were both effective interventions and there were no significant differences between the two group outcomes. Although both groups were effective in addressing BPD symptoms, there were greater benefits of the DBT-SG group for BPD in depression and anxiety ratings as well as participant retention when compared with SGT. While the study received a moderate quality rating, the data analysis did not include clinical significance which presents a limitation when applying the findings to clinical practice.

A quasi-experimental controlled trial by Williams, Hartstone and Denson (2010) looked at the effectiveness of two interventions; a 20-week DBT skills group delivered alongside DBT individual therapy (DBT-individual; n=31) or alongside treatment as usual (DBT-TAU, n=109). A clinical sample was recruited from mental health services with 120 women and 20 men consenting for their routine data to be used. Service data was taken for the six months prior to the interventions, during the interventions and six months following the interventions. A number of confounding variables were accounted for; however, the level of therapeutic intervention, which is an additional treatment for DBT-individual participants, was not adjusted for in the study design. The trial had a high level of non-completion of interventions with a drop-out rate of 32% for the DBT-individual group and 68% for the DBT-TAU group. The high level of drop-out is a weakness, which leads to a moderate global quality rating. Data analysis showed no group differences between those who completed and dropped out of group treatment on age, gender, psychometric scores or service utilisation. Participants in both interventions reported an improvement on outcome measures with no statistical differences between the two treatments. Those receiving DBT-TAU had moderate to large effect sizes for BPD symptoms and depression and a small effect size for inpatient days. Additionally, participants in DBT-individual groups had a statistically significant reduction in A&E visits which was not the case for DBT-TAU participants. This study suggests the

effectiveness of DBT-individual and DBT-TAU is mostly comparable. The difference in drop-out rate may be accounted for by the additional treatment received by participants in DBT-individual and it is not possible to argue this treatment is superior in retention rates when the level of contact with mental health professionals may act as a confounding variable.

A 3-arm single-blind RCT by Linehan and colleagues (2015) compared the effectiveness of a 12-month standard DBT intervention (DBT; n=33), a DBT skills group only (DBST-S; n=33) and a DBT individual therapy only (DBT-I; n=33). Participants were recruited through healthcare practitioners and 99 women who met DSM-IV criteria for BPD took part. This study is less likely to represent the range of people presenting in mental health settings due to the inclusion of women only and multiple criteria around suicidal behaviours. The consideration of confounding variables was acceptable. However, the study design to ensure participants in all three interventions received both an individual and a group intervention did not ensure an equal number of hours. Data collection was a strength and gathered by independent assessors blinded to the conditions before, during and following treatment. The global quality rating is moderate which had one particular weakness in a high level of non-completion of the intervention (8% for DBT, 48% for DBT-I and 39% for DBT-S). There was no statistical difference in the improvement of anxiety, depression or suicide related outcomes between the three interventions at the one-year follow-up. There were significant differences in the anxiety and depression scores with the DBT and DBT-S group improving more than DBT-I on anxiety and depression measures during the treatment year, but participants in DBT-I group improved more in the follow-up year. The authors reported the individual therapy in DBT-I differed in the way it was delivered when compared to standard DBT, which may have impacted on the rate of change differing from the two other interventions. The authors report comparable outcome between groups, but favour standard

DBT due to a higher retention rate. However, this group received more treatment sessions than the other two groups, which may account for the difference in drop-out rate.

McMain, Guimond, Barnhart, Habinski and Streiner (2017) carried out a single-blind RCT comparing a 20-week DBT skills group (DBT-S; n=42) with a waitlist control group (TAU; n=42). DBT-S participants were encouraged to have a crisis support network and all participants continued with TAU. The participants, 66 females and 18 males, were recruited from an outpatient mental health service with minimal exclusion criteria in order to represent the population of people with BPD seen in this setting. The consideration of confounding variables was satisfactory with the only group difference in psychosocial treatment being DBT-S receiving more group intervention than the waitlist control. Assessors were blind to the treatment conditions and completed assessment at pre-, during and post-treatment as well as at 12 week follow-up which is a strength in this study. An acceptable 31% of participants dropped out from the DBT-S intervention. Data analysis was thorough with the utilisation of an ITT sample and analysis of clinical significance. Statistically greater improvements were observed for the DBT-S group when compared with TAU on BPD symptoms, symptom distress and emotion dysregulation after the intervention, but not for depression or self-harm. At the 12-week follow-up it was only emotion dysregulation that maintained statistical significance. Clinical significance and reliability was analysed for symptom distress with no statistical difference between the groups (DBT-S: 47.1% and 20.6%; TAU 41.0% and 20.5%). The global quality rating was strong but fails to demonstrate a strong superiority of a short DBT skills group to other psychosocial therapies as most treatment gains were evened out at the three-month follow-up.

Acceptance and Commitment Group Therapy

A research study by Morton, Snowdon, Gopold and Guymer (2012) explored the use of a 12-week Acceptance and Commitment Therapy group alongside TAU (ACT-TAU; n=21) compared to TAU waitlist (TAU; n=20) in an RCT with a three month uncontrolled follow-up. It was not clear whether the study design was blinded. Participants, 38 female and 3 male, presenting with four or more of the five criteria needed for a BPD diagnosis were referred by clinicians from public sector mental health services. Confounding variables were reasonably controlled for including pre-intervention scores on self-harm, but with higher reports of PTSD in the ACT+TAU group. Flexible criteria around ACT group attendance ensured a minimal loss of outcome data, which is a strength within this study (drop-out of 7.3% from ACT-TAU and 14.7% from TAU). This ensures the study receives a strong global quality rating. The outcome measures were collected before and after the intervention in addition to 13 weeks after the group had finished. Data was analysed using ITT principles and the outcome for ACT-TAU demonstrated improvement in emotion dysregulation, anxiety and BPD symptoms; with 29% of participants showing clinically significant improvements in BPD symptoms. However, there were no significant changes in depression. The analysis showed treatment gains were sustained at the three month follow-up. This study had a number of strengths and demonstrated the benefits of a short ACT intervention, although in the absence of an active control group these treatment gains could be due to therapeutic benefits of additional support.

Metacognitive Training Group

Schilling, Moritz, Kother and Nagel (2015) looked at the effectiveness of metacognitive training for people with BPD (B-MTC; n=22) in an RCT compared with progressive muscle relaxation (PMR; n=24). Their aim was to look at the feasibility of using an eight session B-MTC group delivered over four weeks as an add-on to TAU within an inpatient setting. The

recruited participants were 44 female and 4 male patients meeting DSM-IV criteria for BPD, but the process of the recruitment was not reported. Some confounding variables were considered, although, medication or psychotherapies received as TAU were not taken into account, which is highly likely to change within an inpatient setting. The level of drop-out from the group or level of engagement were not reported, which would be important when determining the feasibility of delivering the group. The assessors were not blinded and both groups delivered by the same clinical psychologist, which may lead to reporting bias. The outcome measure was an appraisal measure that was completed anonymously by participants following each group session. The appraisal measure has not yet demonstrated validity and reliability, which means the result lacks validity. B-MCT participants reported a statistically significant greater use of training, improvements in self-confidence, empathising, perspective taking and a decrease in symptoms when compared to PMR participants. However, the absence of a valid outcome measure and lack of reporting engagement or drop-outs render this study inadequate in determining feasibility or efficacy with a weak global quality rating.

Schilling, Moritz, Kriston, Krieger and Nagel (2018) subsequently completed an RCT with a 6-month follow-up comparing metacognitive training for BPD (B-MCT, n=37) with progressive muscle relaxation (PMR, n=29). Both groups were twice weekly sessions (60 minutes) for a period of four weeks while participants continued standard care that included DBT and individual psychotherapy, which may act as confounding variables. A total of 90 people from an inpatient psychiatric hospital were assessed, with 68 female and six male participants meeting DSM-IV criteria for diagnosis of BPD, and recruited to the trial. A number of confounders were adequately controlled for, although medication, length of stay in the inpatient hospital, other psychotherapies and change of treatment setting were not considered. The study adequately managed the reporting bias with assessors blind to

participants' treatment condition but it was unclear whether participants were aware of the research question. The drop-out rate was not reported, but outcome measure completion was 73% at the end of treatment and 65% at follow-up. Data was collected prior to the first group session, after the last group session and 6 months after group completion. The data analysis used an ITT sample, but there were no statistically significant group differences at the end of the interventions. At the time of follow-up, participants who received B-MCT showed greater reduction in BPD symptoms compared to PMR with both showing medium to large effect sizes. The participants in the PMR group showed greater reduction in depressive symptoms at follow-up. While there is some missing information regarding drop-out from the study it has strengths alongside a thorough data analysis. The study indicates benefits of inpatients accessing short term interventions to improve patient well-being.

Overview of the evidence base for group efficacy

There were 10 studies that received a moderate or strong global quality rating of the 14 reviewed studies (see Table 1.). In order to establish the evidence base for using these interventions, the four studies with a weak global rating were excluded from the summary to ensure the conclusions are not misleading.

Research studies involving DBT, STEPPS and ERGT groups with a duration between 14 and 20 weeks demonstrated comparable outcomes following interventions with improvements in BPD symptoms, depression and anxiety (Blum et al. 2008; Gratz & Gunderson, 2006; Gratz, et al., 2014; McMain et al., 2017; Sahlin et al., 2017, Soler et al., 2009; Williams et al., 2010). The trends of the effects on participants' recovery were large for BPD symptoms and emotion dysregulation followed by moderate for depression and only small effects on level of anxiety. Interestingly, a 12-week ACT group showed a difference in treatment outcome to other emotion regulation skills groups with large effect sizes for emotion regulation and

anxiety, but no observed change in level of depression (Morton et al., 2012). This suggests different emphases within skills teaching may enhance different aspects of well-being.

Research studies that included a follow-up showed the improvement gained in group treatments were sustained during the follow-up period (Gratz et al., 2014; McMain et al., 2017 & Sahlin et al., 2017). However, there were no studies that looked at whether skills are sustained long-term for example 18 months or more. Three studies included a controlled follow-up which showed that the benefits of emotion regulation skills groups were less clear (Blum et al., 2008; Linehan et al., 2015; McMain et al., 2017). At a three-month follow-up, the improvements following a DBT skills groups had levelled out and were similar to a TAU waiting list with the only observed benefit in emotion dysregulation (McMain et al., 2017). Although Blum and colleagues (2008) found that participants who had accessed a STEPPS group continued to maintain treatment gains at a one-year follow-up when compared to people who accessed TAU. The inconsistencies in outcomes may be linked to differences in the treatment as usual within mental health settings. For DBT interventions there were clear benefits for the full intervention and the skills groups only at the end of treatment compared to individual DBT (Linehan et al., 2015). However, at follow-up participants receiving individual DBT therapy had continued to improve and caught up with the interventions that included skills groups.

Studies that included active control groups in varying forms showed a benefit of both the intervention under investigation and the active control group (Linehan et al., 2015; Pascaul et al. 2015; Morton et al., 2015; Schilling et al., 2018; Williams et al., 2010). This suggests that other interventions are potentially equivalent to emotion regulation skills groups in supporting people's recovery from BPD symptoms.

Processes that Facilitate Change

Three research studies looked at the process of change within emotion regulation skills groups (Morton et al, 2012; Gratz et al., 2012; Gratz et al, 2015). These research studies used participant data from studies that have been reviewed above (Morton et al., 2012; Gratz & Gunderson, 2006; Gratz & Tull, 2011; Gratz et al., 2014).

The ACT RCT described by Morton and colleagues (2012) also looked at mediating factors. The sample size varied from 27 to 32 participants as there were some participants who did not complete all scales. The total effect of the ACT treatment on BPD symptoms was significant and this effect was mediated by psychological flexibility, emotion regulation and mindfulness, but not fear of emotions. The contribution of these factors on BPD were analysed and showed that the only mediator with significant effect was emotion regulation. Further mediation analysis of the following emotion regulation subscales was carried out: emotion non-acceptance, goal-directed difficulties, emotion non-awareness, lack of strategies and lack of clarity and impulse dyscontrol. While the total indirect effect of these on BPD symptoms was significant, only impulse dyscontrol was found to be a significant mediator. This study demonstrates the benefits of the ACT intervention were mediated by changes in emotion regulation, particularly through increased ability in managing impulsive behaviours.

A research study by Gratz, Levy and Tull (2012) investigated emotion regulation as a mechanism of change within ERGT. The data was from a previous RCT and an open trial, both reviewed above, with a moderate and weak study quality rating (Gratz & Gunderson, 2006; Gratz & Tull; 2011). The trajectories for DSH and emotion dysregulation were examined using latent growth models. The participants receiving the ERGT had a decrease in DSH over time, which was not the case for the control group. Participants within both

conditions had similar levels of emotion dysregulation at pre-treatment, but with reductions over time for the ERGT completers. A path model was utilised to examine whether emotion dysregulation mediated changes in DSH. The growth model showed a significant path between emotion dysregulation to DSH, suggesting changes in emotion dysregulation and DSH were related. However, this study only investigated limited factors as potential mechanisms of change within ERGT.

Gratz, Bardeen, Levy, Dixon-Gordon and Tull (2015) looked at mechanism of change in ERGT for women with BPD. They utilised data from a previous RCT (Gratz et al., 2014). The results showed the intervention had a significant effect on change in emotion regulation and DSH, as well as BPD symptoms including cognitive, affective, relationship and impulsive symptoms. Structural equation modelling revealed two indirect paths from ERGT to the changes in DSH, one path was through emotion regulation and BPD cognitive symptoms and the other path was through BPD cognitive symptoms only. Further analysis showed change in emotion dysregulation mediates the intervention's effect on DSH through improvements in BPD cognitive symptoms as well as BPD affective symptoms. Improvements during the intervention in emotion dysregulation and BPD affective and cognitive symptoms were positively correlated with improvements in DSH during the follow-up period. However, within a structural equation model the only significant predictor of change in DSH during the follow-up period was change in emotion dysregulation during the intervention. This study demonstrates the mechanism of change during ERGT is related to emotion regulation and the initial improvements in cognitive and affective symptoms, which leads to a reduction in DSH. Although over time the ability to regulate emotions becomes the predictor of a positive outcome.

Overview of processes that facilitate change

All three studies identified emotion regulation as a mediator in the change process for the interventions that were delivered. During a nine-month follow-up period Gratz and colleagues (2015) found change in emotion regulation was the only significant predictor of change in DSH.

Emotion Regulation Skills Groups and Service Settings

The majority of the reviewed interventions (a total of 11 studies) were delivered within community mental health settings. However, there were three interventions adapted to prison and inpatient settings (Black et al., 2013; Schilling et al., 2015; Schilling et al., 2018). One study had a strong global study design and demonstrated the effectiveness within inpatient settings (Schilling et al., 2018). While a further two studies had a weak design they showed the feasibility of delivering emotion regulation skills training in prisons and inpatient settings (Black et al., 2013; Schilling et al., 2015) However, the research by Black and colleagues (2013) suggests community prison settings may not be a suitable setting as there was a 100% drop-out.

Service User Perspectives

The systematic search did not identify any research studies looking at service users' experience of emotion regulation skills groups for people with BPD as stand-alone interventions. The search found one study that looked at the standard DBT programme and another that looked at psychodynamic group therapy which suggest a general lack of qualitative research into the interventions offered to people with BPD. However, these studies are not reviewed here as they are not interventions with a primary focus on skills groups.

Discussion

The aim of this systematic review was to critically appraise the evidence for emotion regulation skills groups for people with BPD and the settings in which they were utilised, as well as exploring the processes that facilitate change. Furthermore, the service user experience was considered an important aspect of evaluating these progressive interventions. Most studies included in this review delivered emotion regulation skills group interventions with a duration of three months or more which is in accordance with the NICE guidance (Blum et al. 2008; Gratz & Gunderson, 2006; Gratz et al., 2014; Linehan et al. 2015; McMain et al., 2017; Morton et al. 2017; Sahlin et al., 2017, Soler et al., 2009; Williams et al., 2010). This showed a variety of groups with a focus on emotion regulation skills were effective in improving BPD symptoms, depression and anxiety, without the prerequisite of specialised individual psychotherapies. Zanarini (2009) argued many effective comprehensive treatments for BPD were difficult to implement in mental health settings and emotion regulation skills groups provide a less intensive therapeutic alternative. While other interventions delivered as a part of treatment for BPD within mental health settings may be effective in reducing depression and anxiety, emotion regulation skills groups appear to lead to more rapid improvement in well-being and superior emotion regulation (Blum et al. 2008; Linehan et al. 2015; McMain et al. 2017). Therefore, it is advantageous to offer a structured intervention such as an emotion regulation skills groups where this is possible as an addition or alternative to other types of treatments.

The reductions in BPD symptoms were mediated by improvements in emotion regulation. This explains comparable outcomes for treatments with differences in their theoretical emphases, as they all focus on developing skills in regulating emotion (Gratz et al., 2012; Gratz et al., 2015; Morton et al., 2012). These findings oppose the argument that change in

emotion dysregulation is facilitated by the experience of emotional patterns within an experiential group environment as this is not encouraged within emotion regulation skills groups (Greenberg and Safran, 1987).

Clinical implications

The majority of interventions demonstrated effectiveness of interventions that were between 12 to 20 weeks whereas year-long interventions showed no clear advantages in clinical improvement to shorter interventions (Linehan et al, 2015). The effects across different emotion regulation skills groups were comparable, which is consistent with the findings that improvement in symptoms is facilitated through reduction of emotion dysregulation (Gratz et al., 2012; Gratz et al., 2015; & Morton et al., 2012). However, the ACT group had better outcomes for anxiety, whereas other groups had better outcomes for depression (Morton et al., 2017). Therefore, it may be beneficial to offer ACT groups for service users who are continuing to experience difficulties in managing levels of anxiety.

Some emotion regulation skills groups have been developed for specific groups of people which has implications for the utility in clinical settings. Emotion Regulation Group Treatment (ERGT) and DBT have been specifically developed for people with a presentation of DSH and suicidal behaviours and ERGT study participants have not included men (Gratz & Gunderson, 2006; Gratz et al, 2014; Linehan et al., 2015 & Sahlin et al., 2017). This is despite the recognition that BPD is equally presented in men and women with a variety of symptoms as a consequence of emotion dysregulation (Grant et al. 2008; Paris, 2018). This means that gender, symptomology and service setting need to be considered when deciding which intervention should be offered. DBT may be more suitable for a population with DSH

and suicidal behaviours, whereas STEPPS and ACT groups can be applied to a range of problems related to emotion dysregulation.

Limitations and future research

The study quality rating tool had a number of strengths including usability for several research designs and demonstrated validity and reliability (Thomas et al., 2004). The assessment tool also had some weaknesses. A moderate individual component rating was given when insufficient information was available to give a rating and the studies' data analysis did not receive an individual component rating. However, all the studies with a strong or medium global quality rating within this review appropriately considered the risk of inflated results either through the study design or ITT analysis.

Little consideration was given within the research studies to people who experience problems in interpersonal relationships and emotion dysregulation but falling outside the diagnostic criteria for BPD (Gratz & Tull, 2011; Gratz et al., 2014; Morton et al, 2012). Therefore, both the efficacy and suitability of emotion regulation skills groups with people who experience traits of, or a subthreshold diagnosis of, BPD needs to be established. People with substance dependence were excluded apart from three studies (Linehan et al., 2015; McMain et al., 2017; Morton et al., 2012). The possibility that people with BPD access a range of services depending on their presentation was only considered by a minority of studies (Black et al. 2013; Sansome & Sansome, 2011). Future research needs to include those who fall outside the criteria for BPD diagnosis and who present within different services to ensure they receive adequate treatment for their emotional distress.

The current review intended to include service users' perceptions of the use of skills-based group interventions, as there has been an increased use of these groups within community mental health settings. However, it was not possible to identify research that included the views of people who had taken part in emotion regulation skills groups. This could have implications for practice as this population experience emotion dysregulation and have difficulties in maintaining relationships which may impact on their experience of psychotherapeutic group interventions.

Conclusion

The evidence suggests that emotion regulation skills group approaches, including DBT, STEPPS and ERGT, are helpful to people with BPD with comparable outcomes for group interventions lasting 14 to 20 weeks. The improvements observed within these interventions appears to be facilitated by teaching people to cope with intense emotions by improving their emotion regulation skills.

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SECTION B: Major Research Project

The experience of taking part in brief group therapy (STEPPS-EI) when living with emotion dysregulation: An interpretative phenomenological analysis

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Abstract

Background and aims: People with emotional intensity difficulties experience difficulties regulating their emotions without meeting the threshold for a borderline personality disorder diagnosis. STEPPS-EI is a newly developed intervention that addresses the problems experienced by this population. This study explored the experiences of people living with emotional intensity difficulties and their relationship to other group members and facilitators within STEPPS-EI. It also looked at any other meaning the group may have and the impact on people's existing relationships.

Design and method: Interpretative phenomenological analysis (IPA) was utilised to explore the idiographic understanding of participants' experiences. Participants were recruited through an NHS trust and interviewed using a semi-structured interview. These were subsequently transcribed and analysed using IPA.

Results: Three superordinate themes emerged: An emotional journey, developing group relationships and developing and understanding self.

Conclusion: The findings suggest individuals are on an ongoing emotional journey and experiences within STEPPS-EI become a part of this. Relationships within the group environment were impacted by differences between group members and require active management by group facilitators. Joining the journey of other group members appeared to improve people's understanding of themselves, their ability to regulate emotions and the relationships with others.

Keywords: Emotion dysregulation, emotional intensity, borderline personality disorder, STEPPS-EI, group dynamics.

Introduction

Borderline Personality Disorder (BPD) and Personality as a Continuum

People with a diagnosis of BPD have difficulties in regulating rapidly changing emotions and act impulsively in response, which leads to problems in managing interpersonal relationships (American Psychiatric Association [APA], 2013). The emotional distress is linked to a range of further difficulties including low self-esteem, feelings of emptiness and impulsive coping mechanisms (APA, 2013). The bio-social theory suggests BPD is linked to a biological sensitivity and aversive experiences in childhood which leads to changes in emotion regulation abilities (Neacsiu, Bohus & Linehan, 2014). This results in heightened physiological sensitivity and reactivity which is compounded by insufficient learning around emotion labelling, tolerating and regulation (Crowell, Beauchaine & Linehan, 2009). Difficulties regulating emotions have also been linked to functional impairment within non-clinical populations (Trull, Useda Conforti & Doan, 1997). Those with traits of BPD have poor emotional perception and management of their own and other people's emotions (Gardner, Qualter & Tremblay, 2010). This suggests BPD is better conceptualised on a continuum where an increasing level of pathology becomes expressed in a growing number of symptoms (Livesley, 2018).

Emotion Regulation

Emotion regulation enables an individual to respond flexibly to situations which provoke strong emotions with a range of behaviours that are socially acceptable. People with BPD have difficulties regulating their emotions and as a result behave in ways that precipitate negative responses from people, which increases the strength of their emotional experience and difficulties (Carpenter & Trull, 2013; Cole, Michel & Teti, 1994). Emotion dysregulation is a problem in managing aversive emotional experiences, intense physiological arousal,

attentional focus, and achieving goals when experiencing intense emotions (Neacsiu et al., 2014). This difficulty in regulating emotion is also a key problem for people who fall below the threshold for meeting all the criteria for a diagnosis of BPD (Blum, Bartels, St. John & Pfohl, 2018).

Individual agency is a core within the concept of emotion regulation with three key features of goal, strategy and outcome (Gross, 1998; Gross & Barrett, 2011). The modal model suggests emotions are generated through the sequence of a given situation, attention of the individual, the meaning this generates and the response which in turn impacts and potentially changes the situation (Gross, 1998). The process model of emotion regulation proposes that strategies for regulating emotions can occur at any of the points in this sequence to achieve a desired outcome. Strategies include situation selection, situation modification, attentional deployment, cognitive change and response modulation (Gross, 2014). Theoretical concepts and techniques utilised for therapeutic change within psychotherapies such as Dialectical Behaviour Therapy (DBT) and Schema Therapy correspond to the strategies outlined in the process model of emotion regulation (Fassbinder, Schweiger, Martius, Brand-de Wilde & Arntz, 2016).

What are Emotional Intensity Difficulties?

Within clinical settings, emotional intensity difficulties describe service users with "emotions [that] tend to come on more quickly, be more intense and last longer" (p. 5; Hall, 2014). This population is considered emotionally sensitive and appear over-reactive to others, which is a feature within developmental models of BPD (Wall, Kalpakci, Hall, Crist & Sharp, 2018). The difficulties in regulating emotions lead to intense emotions and subsequently feelings of distress. Emotional intensity difficulties can be considered a part of the dimensional view of

BPD describing a population who are functionally impaired, but fall below the criteria for a BPD diagnosis.

Implications for Improving Access to Psychological Therapies (IAPT) Services

IAPT services were developed as a response to recommendations within the National Institute of Health and Care Excellence (NICE) guidelines for delivering psychological therapies to people who experience mild to moderate depression and anxiety (NICE, 2011a; NICE, 2011b; Clark, 2011; The Centre for Economic Performance's Mental Health Policy Group, 2006). While statistical data suggests 67% of service users accessing IAPT services experience a reliable change in symptoms, only 51.6% move into a recovery status (Health and Social Care Information Centre, 2018). This leaves a number of people who continue to experience anxiety and depression following treatment. Co-morbid personality disorder has been associated with a reduced recovery rate and may account for less improvement in functioning and symptoms when accessing the therapeutic interventions on offer (Goddard, Wingrove & Moran, 2015). As a response, IAPT services have started to identify ways to address the needs of those who may experience depression and anxiety as a result of sub-threshold BPD and emotional intensity difficulties.

Systems Training for Emotional Predictability and Problem Solving- Early Intervention (STEPPS-EI)

STEPPS-EI is a therapeutic group intervention adapted to IAPT services for people with emotional intensity difficulties or subthreshold BPD diagnosis. STEPPS is a time-limited intervention with demonstrated effectiveness in addressing emotion regulation with research supporting its utility in a range of services and countries (Blum et al., 2008; Bos, van Wel, Appelo & Verbraak, 2010). The original STEPPS group has been implemented in secondary

mental health services within 15 counties in the UK. Its strengths are that it is manualised, economical and can be implemented alongside existing treatments (Harvey, 2017).

STEPPS-EI is a shorter version of the skills-based programme delivered over 13 sessions (Black, Blum, Pfohl & St. John, 2004, see appendix C). Initial pilot data from the delivery of STEPPS-EI suggests service users who take part improve in symptoms; however, there is currently a lack of evidence for this adapted version of STEPPS (Harvey, 2017). The sessions are delivered in a classroom format by two mental health professionals with a focus on the development of skills and reframing problems rather than individual group members' difficulties. The first step is awareness of emotional intensity and is partly based on cognitive filters from Schema-Based Therapy (Young, 1999). The second step is emotional management which teaches people to identify when a cognitive filter has been triggered and develop the skills to manage an episode of emotional intensity. The third step is behavioural management and considers functional areas that may be impacted by the interplay between emotional intensity and the social environment (Blum, Bartels, St. John, & Pfohl, 2018). These three steps are delivered in modules and group members are able take a break once a module is completed if needed and re-join another STEPPS-EI cohort to finish the intervention.

Emotional intensity difficulties and group relationships

Therapeutic groups have a range of added benefits to individual psychotherapy. The group environment provides opportunity for the development of group cohesiveness which enables self-disclosure, reduced isolation, feelings of catharsis, observing others change, increasing feelings of hope and motivation for change (Vinogrador & Yalom, 1989). However, group therapy requires individuals to manage multiple relationships with group members, the group

facilitators and the group as a whole. For service users who have difficulties with emotion regulation this is a challenge, as they experience greater feelings of aversion, fears of rejection and failure (Stiglmayr et al., 2005; APA, 2013). Group interventions for people with BPD have been linked to chaotic group processes that can be difficult to manage for therapists (Sagen Inderhaug & Karterud, 2015). Professionals appear to experience discomfort elicited by the maladaptive coping behaviours of people with BPD and can feel uncertainty about how to respond therapeutically (Commons Treloar & Lewis, 2009).

The experiences of service users

Recent research has started to explore group interventions for people diagnosed with BPD and the challenges this presents (Barnicot, Couldrey, Sandhu & Priebe, 2015; Bond, Wright, & Bacon, 2017; McSherry, O'Conner, Hevey & Gibbons, 2012). The development of trust is viewed as essential; however, this process requires more time within group therapy than individual therapy (Lonargáin, Hodge & Line, 2017). People have expressed a desire to improve their relationships as a part of their recovery, although this is a difficult area in their lives due to invalidating or abusive early childhood relationships (Katsakou et al., 2012). The opportunity to experiment interpersonally with group members has enabled people with BPD to change relationships outside the group environment when taking part in mentalization based group interventions (Johnson, Mutti, Springham & Xenophontes, 2016). While service users experienced skills groups within DBT as normalising and validating, they also recognised learning was demanding and could become overwhelming (Little, Tickle & das Nair, 2018).

Focus for this study

STEPPS-EI is considered a group intervention which supports individuals to develop new skills in managing emotion regulation and relationships. There is a lack of studies exploring the experiences of service users with emotional intensity difficulties and BPD in this type of group setting and, in particular, those where service users are not supported by an individual therapist. With the expansion of services for people who experience emotional intensity difficulties and do not meet the threshold for BPD, the subjective experience is important in terms of their perception of managing relationships. Therefore, this study aims at exploring the following areas from the service user's perspective:

1. What are service users' experiences of the STEPPS-EI group and its meaning to them?
2. What are service users' perceptions of the relationship with facilitators and other group members?
3. How do service users perceive the group experience and the effect on their relationships with people in their everyday lives?

Methodology

Design

A qualitative methodology was utilised as this type of enquiry is concerned with the idiographic understanding of participants' experiences. Interpretative phenomenological analysis (IPA) was chosen for this study as this approach is grounded in the interest of people's understanding of their own experiences and what holds particular significance to them (Smith, Flowers & Larkin, 2009). It is based on phenomenological philosophy where lived experience is considered as it appears to our conscious, including a focus on relatedness

and the interconnected way we create meaning when engaging with the world (Tuffour, 2017; Smith et al., 2009). It is also influenced by hermeneutics which is concerned with the foundations of how interpretations are made when analysing text. Within IPA the meaning may be hidden in the text, and the researcher seeks to interpret this putting aside their own preconceptions (Smith et al., 2009).

Participants

The participants were four men and six women who had participated in STEPPS-EI. They were estimated to be in the following age ranges: two were between 18-25, two between 26-35, three between 36-45, and three between 46-55. Five said they were working at the time of the interview, three were on benefits, one was studying (but taking time out) and one person did not say. One person reported he had adult children, two reported they had children living at home and two people reported having a partner. Eight participants were white British and two participants were from ethnic minority groups. Two participants had taken a break between module two and three and joined another STEPPS-EI cohort.

The inclusion criterion for this research project was to have taken part in the introductory module and the two modules of STEPPS-EI while allowing for two sessions to be missed in each module. Participants were recruited from an NHS mental health trust in the UK (South-East England) that delivered STEPPS-EI. Participants were recruited from three STEPPS-EI groups by a researcher visiting the groups and offering the opportunity to take part in research. Participants who expressed an interest were given a participant information sheet regarding the research (see appendix D). Potential participants were contacted to answer questions and to arrange a time to meet.

In order to access STEPPS-EI, service users needed to meet five criteria out of ten on the McLean Screening Instrument for BPD (Zanarini,Vujanovic, Parachini, Frankenburg, & Hennen, 2003; see appendix E). To manage the level of risk, the following presentations were excluded by the service: taking illicit substances including alcohol to excess, on-going physical health problems which impact on the ability to attend the course, a history of severe and enduring mental health problems, or a personality disorder diagnosis.

Procedure

A semi-structured interview was developed on the basis of the research questions (see appendix F). This is the recommended method for the purpose of data collection in IPA as it invites rich data and explanation of individual experiences (Smith et al., 2009). A person with lived experience, who is a member of Salomon's Advisory Group Experts (SAGE) was consulted to review the suitability of the interview. This was followed by a pilot interview with a colleague who had recently taken part in a therapeutic group to check the length and feasibility.

Particular attention was given to the development of rapport during interviews and the researcher used 'active' listening skills to conduct the interview (Smith et al., 2009). The semi-structured interview schedule was used to focus the interview, but the unpredictable experiences and concerns of participants were encouraged to guide the conversation to ensure their lifeworld was reflected in the dialogue that took place (Smith, et al., 2009). The interview schedule had minor changes according to feedback received from participants. The interviews were between 45-120 minutes and took place on NHS premises which ensured the space was quiet and confidential. Interviews were audio recorded and subsequently transcribed.

Data analysis

The method for adopting IPA has been summarised into four stages: "1. first encounter with the text, 2. preliminary themes identified, 3. grouping themes together as clusters and 4. tabulating themes in a summary table" (p. 218, Biggerstaff & Thompson, 2008). This involved listening to the interviews and reading the transcripts while making notes focusing on how each participant related to their experience by paying attention to their descriptions, use of language and emerging concepts (Smith et al., 2009; see appendix G). This was to ensure that the subsequent development of preliminary or emerging themes was grounded in the participants' experiences. The emerging themes were clustered together in groups using abstraction and polarization (see appendix H). The clusters were then analysed across participants and themes of contextualisation and function created new super-ordinate themes (Smith et al., 2009; see appendix I). A strategy of continuous comparison was used to ensure all themes were consistent and included for each participants.

Quality Assurance

The quality of the research was considered using Yardley's (2000) four principles. *Sensitivity to context* was considered in several ways including the choice of IPA itself to ensure close engagement with participants' lived experience of therapy and enabling them to lead the focus of the interview. The grounding of the interpretations are demonstrated within quotes from the transcripts. The *commitment and rigour* of the initial analysis was reviewed by the research supervisor as well as the process of the development of superordinate themes. While moving from clusters of emerging themes to creating superordinate themes, these were thoroughly checked by returning to consider the initial emerging themes to ensure consistency across participants within superordinate themes. In the process, particular attention and commitment to ensuring the voice of each individual was presented in the

written material as well as themes across participants. *Transparency and coherence* is demonstrated through use of participants' quotes to underpin the themes in the results section. Respondent validation was used to check participants' views on themes with the opportunity to incorporate those into the data analysis (see appendix J) (May & Pope, 2000). Reflexivity was an important part of the process and a bracketing interview took place before the data analysis (Ahern, 1999) as well as a reflective diary through the project (Smith et al., 2009; see appendix K). IPA research should have *impact and importance* and while there are theories giving suggestion to what experiences people may have in group therapy, this particular client group have not shared their own experience of what this means to them and is therefore considered a valuable contribution to research.

Ethics

The research was carried out according to the British Psychological Society's Code of Conduct and ethics approval was given by NHS Research and Ethics Committee as well as the NHS Trust Research and Development Department (British Psychology Society, 2009; see appendix L and M). Particular attention was given to confidentiality and data security. Interview recordings were stored as encrypted electronic files on encrypted universal serial bus (USB) sticks. The electronic files were destroyed once the transcription of interviews was complete. Transcripts were anonymised by excluding any identifying information and using pseudonyms for participant names. Transcripts will be stored securely by Canterbury Christ Church University for 10 years.

Participants were given the opportunity to re-read the information sheet before consenting to be interviewed (see appendix N). The emotional state of participants was monitored through the interview followed by a debriefing to address any concerns. The service and the GP were

informed of their participation should the participant become distressed after the interview (see appendix O). Following difficulties in recruitment, participants were paid £20 to cover travel and any additional costs.

Results

Three superordinate themes emerged through the IPA of transcripts, which were as follows: an emotional journey, developing relationships, and developing and understanding self. Within the themes, a further 15 themes were identified and these are shown below (see Table 1.). Themes discussed by each participant are shown in Table 2.

Table 1.

Superordinate themes and themes

Superordinate Theme	*Theme*
An emotional journey	Managing emotional distress Managing shame and stigma Managing expectations and engagement Persevering in the face of emotion dysregulation Revising understanding of emotional world Ending as emotionally crucial Further challenges ahead
Developing group relationships	Developing trust with group members Coping with difference in the group Developing trust with facilitators Questioning facilitators' competence
Developing and understanding self	Shared experience helped understanding of self Developing awareness and ability to manage emotion dysregulation Developing skills to manage relationships Developing agency and capacity for change

Table 2.

Summary of participants' themes

Theme	Ian	Julia	Steve	Leafy	Sarah	Simon	Hannah	Roger	Fiona	Sue
Managing emotional distress	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Managing shame and stigma		✓				✓		✓		
Managing expectations and engagement	✓	✓	✓		✓	✓	✓	✓	✓	✓
Persevering in the face of emotion dysregulation	✓	✓	✓		✓	✓		✓		
Revising understanding of emotional world			✓	✓		✓		✓		✓
Ending as emotionally crucial		✓	✓	✓	✓	✓	✓	✓	✓	✓
Further challenges ahead	✓		✓	✓	✓	✓	✓	✓	✓	
Developing trust with group members	✓	✓	✓	✓	✓	✓	✓	✓		✓
Coping with difference in the group	✓			✓	✓	✓		✓	✓	✓
Developing trust with facilitators	✓	✓	✓	✓	✓	✓	✓		✓	✓
Questioning facilitators competence		✓	✓	✓				✓		✓
Shared experience helped understanding of self	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Developing awareness and ability to manage emotion dysregulation	✓	✓	✓	✓	✓		✓	✓		✓
Developing skills in managing relationships	✓	✓	✓	✓	✓		✓	✓		✓
Developing capacity for change and agency	✓		✓		✓		✓	✓		

An Emotional Journey

A superordinate theme around the emotional journey emerged with participants coming from a place of distress prior to therapy and seeking help, then engaging with therapy and lastly looking to the future. Seven themes reflected this journey: managing emotional distress, managing shame and stigma, managing expectations and engagement, persevering in the face

of emotion dysregulation, revising understanding of emotional world, ending as emotionally crucial and further challenges ahead.

Managing emotional distress

The participants described difficulties in managing emotional distress and had made previous attempts to address this before taking part in STEPPS-EI. They talked about their individual struggles and Sarah stated that the ongoing problems with *"the last ten years of, yeah, emotional problems really, depression and things"* led her to taking part in STEPPS-EI. Most participants had previously received therapeutic interventions for other episodes in their lives and were persevering with seeking help in order to manage emotion dysregulation. Roger described wrestling with becoming unwell again and not wanting to go through the process *"having gone through this four or five years ago, I don't know, I think I was a bit too defiant not wanting to admit that I was ill again, 'cos I had worked so hard at getting myself better"*. For Steve the help seeking process had been particularly difficult as he did not receive help for emotional intensity difficulties for several years: *"For a good two years I'd sought help and sought help and ... only through the drugs route did I get talking therapies"*. Four participants felt there was a lack of alternative treatments to enable them to manage their distress with Julia describing her frustration with the lack of holistic therapies on offer: *"I think that doctors give away these sweets, these pills too readily and I think maybe homeopathy and umm alternative forms of medicine and healing should be more available on the NHS".* Others told of a lack of therapeutic options which were appropriate to their needs such as individual therapies for emotional intensity difficulties, or feeling STEPPS-EI was not quite right for them. Fiona told about the dilemma of no alternatives as she was unable to relate to the experiences of others within STEPPS-EI: "*Um yeah a pattern, it's like wanting to help myself so I didn't want to stop going, but then feeling it wasn't you, this wasn't actually helping me"*. There were also participants who talked about STEPPS-EI as an

alternative to taking medication to manage emotions and Leafy described the pressure to take medication: "*They'd be like "just take meds" and I was like I really, I really don't want to [ ] so then they eventually started talking about the STEPPS".*

Managing shame and stigma

Managing stigma in the responses from others about their mental health difficulties as well as their own feelings of shame was a part of the journey. Three participants shared their experiences of stigma expressed by people who were gatekeepers to services, leading to increased feelings of shame around experiencing mental health issues. Julia told how she had to persevere to access mental health services and how the GP appeared to stigmatise therapy, which enhanced her own sense of shame as well as creating an expectation of group members being very unwell. Julia recalled her GP's response:

""Oh there is a group for people with emotional intensity, oh but you would not come under that category" and I went "but you don't know anything about me, okay I might look like you know, smartly dressed and whatever but I do have emo[tional difficulties]" so I thought that annoyed me because actually that's why when I got there I was expecting people to be really messed up and in fact they were really articulate and nice together ".

Simon shared his feeling of shame around struggling to manage emotions as he should be able to "*man up*". This appeared to make it difficult to share problems with others and Roger described his journey through this: *"I completely shut myself away from everyone and everything because I was so ashamed that I got ill, I couldn't really understand it…".*

Managing expectations and engagement

The ability to manage their own expectations of therapy was a part of the process of engaging with STEPPS-EI. This appeared to be influenced by other sources or experiences. For example, Julia thought group therapy would be delivered in the way it is portrayed on

television: "*I thought we'd all be sat around in a circle 'cos what you see on TV and everything, don't you in therapy? It's always like that"*. The expectation of a social pressure to talk led participants to experience anxiety around engaging with STEPPS-EI. Hannah described her reluctance around this: *"I kind of... thought it would be kind of like uh how one to one counselling is, but obviously in a big group, so you'd have to, you know talk to whoever is there, as well, in front of other people, so that's kind of what I thought it would be like before, so I wasn't really too keen on it*".

Most participants seemed to experience the content within STEPPS-EI as engaging, but there were a range of views about the course structure. These varied from enjoyment of the formal structure to feeling disengaged by the format with Ian explaining that the satisfaction with something formal was unlike him: *"I quite liked the format of the course it was really, it's the opposite of what I would normally like in my real life if I was learning something"*. Steve described mixed feelings with the delivery feeling too formal and "*perhaps the delivery slightly school like"*, however, at the same time *"the content from that first session I was like "oh I'm definitely doing this""*. Participants experienced the support of homework differently with some finding it engaging, some confused by it and others feeling rushed by the volume.

Persevering in the face of emotion dysregulation

When embarking on the journey through STEPPS-EI participants had difficulties with emotion regulation but became committed to persevere despite their problems. The therapeutic process was a challenge and Steve told how he felt *"part of getting better is pain unfortunately it's really harsh, it's so harsh, it's probably why lots of people won't get better".* The difficulties in regulating emotions resulted in participants using sex, food, writing, medication and humour in order to cope. The use of humour also seemed to enable sharing of experiences in the face of the emotion dysregulation and Julia explained *"it was*

quite funny laughing about stuff, but that's just my way of dealing with things anyway". Ian explained how he persevered on the journey: "*it is just like digging your heels in and it was kind of something you just say "[ ] I'm going to just go and however I feel about it I'm just going to go and do it" and you feel better and that was kind of there was a bigger lesson in that"*. For Steve and Simon the difficulties in regulating emotions led to feeling a need for additional one-to-one support with Simon explaining "*I felt like I needed like to talk about, to the facilitator or someone, about something personal, it, it wasn't enough time to do that*".

Revising understanding of emotional world

A part of STEPPS-EI is to support group members' understanding of their mental health problems and for some this was a helpful process where others found this more difficult. For two participants there was a sense of confusion regarding what it meant to have emotional intensity difficulties and this made it difficult to understand what they were journeying with. There were also two participants who felt they should have been better prepared for the content of STEPPS-EI. Leafy was surprised as she had previously been diagnosed with PTSD, anxiety and depression *"which I'm firmly sure that I don't have any of, but that's not the point and then going to read this thing "oh yeah this is, this is what your life is, this is your life" was really odd, it was nice, but also hard at the same time"*. For Roger the use of the term 'personality disorder' within course material distracted him from learning skills as he struggled to adjust and revise his understanding: *"a heads up, so I could have accepted that before I got there and be prepared for it, would have been extremely helpful, 'cos like I said I then it was all about realisation and not really learning I don't think"*. While some struggled others were able to revise their understanding of their emotional world. Sue had managed to make sense of her emotional intensity difficulties as a mental illness: *"I see it now as an illness rather than me just being nutty"*.

A diagnosis was an important part of the journey for three individuals as it was seen to validate and explain the internal turmoil. For Roger the lack of a diagnosis by a psychiatrist became a barrier to adjustment and he explained: *"this is what I find insulting, that I'm not entitled to a diagnosis or this crappy half diagnosis, (sounding tearful) how insulting to say I'm not gonna do my best to learn to manage my condition"*. Two people saw intense emotions as a positive part of themselves. Leafy saw it as a special power to be used for good despite being presented as a negative within STEPPS-EI and attempted to help others revise their negative experiences of intense emotions by sharing her thoughts: *"it's like we have this super power that no one else has and obviously it has its down side [ ], but we will be like happier than anyone else will ever be over like a leaf that we've found"*.

Ending as emotionally crucial

The ending was important to the participants' emotional well-being and how this was dealt with was described as a crucial part of the therapeutic process. Leafy experienced the ending as essential and rearranged a house move around the final session as the date was changed; she explains: *"if there wasn't like a specific ending to things then I'm like, argh I've got all of these feelings and I don't know where to put these and then I cannot go away"*. People wanted to know where to go for help after the ending and some felt uncertain about this while others felt reassured. Sarah believed the knowledge of something being available was enough for her to feel at ease: *"I know it's not, it's not gonna be perfect or anything, but just knowing that there's that small thing there just in in case, in case I get back to a bad place or whatever"*.

For two participants the ending was linked to intense emotions. Steve shared how emotionally difficult the therapeutic process had been and "*if I wasn't as well as I was by the end I would have really <u>really</u> felt a sense of abandonment"*. For Julia, missing the ending

due to facilitator sickness left her feeling "*let down really big time*" as she felt "*you need a conclusion* [ ] *because it was quite intense"*.

Further challenges ahead

As participants came to the end of therapy there was a sense of further challenges ahead. Some felt more therapy was needed despite feeling they had improved, and others continued to feel distressed. For Hannah there were areas in her life that had changed, particularly around her own understanding of emotional reactions and helping others appreciate her experiences, but she explains "*I think that the way I understand it has developed more than the way I can handle it"* and that "*it did help me a little bit, not, not as much as I'd hoped it would"*.

However, two individuals found they struggled more following the group. Fiona described a lack of connection with group members and their experiences of emotion dysregulation as she felt she didn't have emotional intensity difficulties. This led to the group being ineffective and left her with a feeling of failure: *"for me it just kind of adds to a pattern of feeling, it's not rational, but the feeling is one has failed even though it wasn't my fault"*.

Developing Group Relationships

This superordinate theme encompassed the participants' thoughts on the development and management of relationships with group members and facilitators. The following themes emerged through the analysis: developing trust with group members, coping with difference in the group, developing trust with facilitators and questioning facilitators' competence.

Developing trust with group members

The development of trust was an important aspect of the group environment and sharing experiences was needed to establish this. While the group environment was described as

comfortable, the development of trust seemed to require a willingness to be open. Sue described how telling group members about her difficulties in regulating emotions increased their level of trust and ability to share:

"I felt, you know, happy that I had sort of um put myself out there to make them, the others that didn't feel comfortable talking, but made them at ease a little bit more and then I did notice after and then the next session others were talking".

Four participants found it difficult to develop trust with the whole group. Roger explained how others not opening up made him think *"why am I opening up when you're not"* and Sarah felt it was difficult to engage with the whole group: *"I find it very difficult to talk in front of other people, especially about personal issues 'cos I have no idea who to look at or who exactly who I'm addressing".*

Coping with difference in the group

The experience of feeling different to other group members and coping with this impacted on participants' ability to engage with STEPPS-EI. They had to cope with differences in age, gender or how people reacted to evidence of emotional dysregulation, such as self-harm or aggression, which made it more difficult to relate to other group members. Simon found it problematic to connect with others in the group and he felt *"it was difficult [ ] I think they were all a bit younger, like all, yeah mainly females"* and it left him feeling uncomfortable as "*it was a bit weird".*

For Fiona, the experience of emotional difficulties was different to other group members which meant she was unable to relate: *"none of it spoke to me or made sense to me, uh and I'd say for the majority of the people that were there it did, and they were able to then talk about particular examples of then what happened, but it's just not, I don't work in that way".* She had to cope with feelings of isolation, which was added to by being challenged on her

suitability for the group by a group member and this led to her feeling more alone *"it did feel quite rejecting and so I just felt.. it made me feel low and alone"*.

Three participants expressed that the ability to cope with some difference led to the group becoming more comfortable as there seemed to be an acceptance of group members as individuals. For example, Ian experienced the diversity of the group alongside similarities in emotional difficulties as a positive: *"I like that we're all so different and there's lots of little crossovers"*.

Developing trust with facilitators

Trust with facilitators was highly valued and developed through supportive experiences within the group environment and outside of the group. Participants felt trust was established through tasks carried out by facilitators such as empathy, checking people were safe, engaging all group members in discussions, maintaining boundaries, professionalism and advice giving. Hannah described how the facilitators made her able to approach them for support: *"they did kind of encourage us to talk to them one on one after the group if we weren't feeling, if we were feeling uncomfortable or distressed or whatever"*. For Steve, trust was nurtured through a facilitator relating empathically: *"the reason why she could communicate with me was because she empathised with me and she communicated from a place that I understood"*.

Questioning facilitator competence

While trust was developed with facilitators, some participants also felt uncertainty around the competency of facilitators across the different STEPPS-EI groups. Three people questioned the facilitators' understanding of emotional intensity difficulties in terms of the way they related to the topic and responded to the participants. Steve described feeling uncertainty due to inconsistencies in the way facilitators managed the group:

"One thing that I find helps me as somebody with emotional intensity is consistency, consistency of umm, one thing I've suffered from perhaps is easier to say is inconsistencies in people's emotional responses to me or my- my perceived responses from people, inconsistency can hurt".

Five participants struggled with frustrations around the way in which facilitators managed group dynamics with feelings that group members were not encouraged enough to join in and not managed when going off topic. Sue said *"I think also maybe that they could have … maybe … argh I don't know maybe have made it easier for others to talk"* while Roger felt frustrated with "*a lot of time wasting there really was and that's frustrating*".

Developing and Understanding Self

Through their journey, participants began understanding and developing a sense of themselves living with emotional intensity difficulties. Within this, four themes emerged: shared experience helped understanding of self, developing awareness and ability to regulate emotions, developing skills in managing relationships and developing agency and capacity for change.

Shared experience helped understanding of self

The shared experience of having difficulties in regulating emotions enabled group members to feel less isolated and reduced confusion about behavioural actions when distressed. Julia described her experience: *"I suppose it made me feel like I was able to relate to that and uuh maybe as a consequence feel less confused about it* ". For Ian, hearing about other people's difficulties in regulating emotions enabled him to use comparison to clarify his understanding of his own reactions:

"Just watching somebody probably for the first time, not only saying what they did, but why they were doing it and actually to watch them pick apart their own motivations [ ], and doing

it yourself, trying to pick apart what parts of that are the reasons for your own destructive behaviours".

The shared experience also appeared to develop the participants' understanding of themselves as 'normal' people. Ian explained how this helped him: *"you kind of get people there who are just coming at different things, and it's nice because you sometimes feel a little bit, I felt a little bit less broken"*. Participants were relieved when realising they were not the only one with difficulties in regulating emotions. However, feelings of commonality seemed to differ between participants and depended on the shared experience of how this was expressed in behaviours. For some, this meant self-harm or external ways of showing distress, for others it was a withdrawal or use of substances to cope. For Sue, it took some time to feel she had something in common with group members, but once she found others with similar coping strategies she felt: *"I think probably a relief that I wasn't alone, that I wasn't the only one there that suffered emotional intensity the way that I suffered it"*. For Fiona, taking part in STEPPS-EI was difficult as she struggled to relate to descriptions of other group members' experiences of emotion dysregulation. However, she felt a sense of connection in the struggle with mental health problems: "*I did relate to things people were saying […] I mean that level you know, just a group of people who were struggling in their way"*.

Developing awareness and ability to regulate emotions

Participants developed an awareness of their emotion regulation processes and the ability to regulate these through use of skills learned within STEPPS-EI. Some participants became more aware of situations where they struggled and Julia noticed the unhelpful coping habits she used to manage her feelings: *"I seem to be more mindful of my, of my self –destruction and umm.. I think maybe I'm more aware of myself in general with my moods and my behaviours, you know reactions, so that's been really positive".* While Roger continued to

find it difficult to manage his emotions he noticed: *"I'm very much aware of my automatic negative thoughts, I'm very much aware of trying, when I'm well enough to, trying to put something positive in place"*.

The learning within STEPPS-EI led to the development of skills in regulating emotions for some participants. This meant participants were able to feel in more control when experiencing intense emotions and Sarah said: *"I'm able to when I'm feeling emotionally intense and everything, I don't, it doesn't feel like quite the end of the world anymore, like it*s *fine, I can get over this, it's a way to deal with this*". For Steve there were a number of unhelpful strategies that enabled him to cope with the challenges of taking part in STEPPS-EI, however, as he approached the end this changed: *"I feel like I have the blue print for a healthy life, with a lot of hard work and a lot of honesty, or every day, because it only takes me a day or two to be ill again if I'm not looking after myself"*.

Developing skills in managing relationships

Emotional awareness and the skills in regulating emotions enabled some participants to improve relationships with friends and family members and other participants developed new relationships. This happened through variable processes such as accepting relationships were imperfect, explaining their emotional world to others and becoming assertive around their own needs. For Leafy it was the improved ability in explaining her feelings and reactions to her parents that changed the relationship: "*so that was, that was nice and I have got my relationship with them is so much better*". Developing relationships seemed to be an emotionally challenging task and Sarah described the worries around becoming assertive when she realised how others were increasing negative emotions: "*It's terrifying and it's upsetting still, but it prevents so much more upset and things in the long run and it probably it's not like a quick fix or anything, but a situation where I would have just shut down*

completely I was actually able to not shut down and just say like be like "no I'm, I'm, I'm not just gonna accept this".

For five people there was a changing understanding of relationships with others which enabled them to make changes. This also raised difficult feelings including sadness and guilt. There were some individuals who felt sadness when understanding their difficulties with trusting important others. Ian described ongoing trust issues:

"*I've been as honest with them as I have with you and it was interesting to hear what … people have to say about that, but I'm saddened by that anyway, I mean I can-I can trust with what I'm giving them, but it's not fundamental to me*".

Others felt guilty when realising they relied on others. Sue made changes to the way she related to her children as a result of her awareness:

"It made me aware of how much I relied on my children for support and that maybe I need to rely on others like such as friends [and] other family members for support rather than my children, because they're my children and it should be me that they are coming to".

Developing agency and capacity for change

The participants' agency and increased capacity for change emerged as a theme, which created feelings of hope for the future. For Sarah, the emphasis within STEPPS-EI on the value of lived experience was empowering and she shared her feelings on this: *"I just liked that whole concept of like yeah having, having means to help yourself but not precisely knowing how to apply it correctly"*. The importance of individuals within the group and their ability to support other group members was explained by Ian using a metaphor of wholeness:

"I love that people just bringing their own bits of sanity to the table rather than their own bits of insanity [] umm and a lot of our holes seems to not overlap, so people kind of, it is like putting two punch cards over the top and, and combined there's no holes there".

The changes participants experienced in themselves appeared to create a sense of capacity and hope for managing situations in the future and Hannah shared where she was at: "*I feel really good about it, I feel I've grown [] I'm still trying to grow and overcome whatever I'll go through"*.

Discussion

This study explored the experiences of service users who had taken part in STEPPS-EI and their views on relating to others within a group environment. It also explored what meaning the group had to participants and the impact on relating to significant others. The findings suggest the individuals living with emotional intensity difficulties are on an ongoing emotional journey. The experiences within STEPPS-EI can be understood as a part of this and joining the journey of other group members appeared to improve their understanding of self and the relationships with others.

Findings

The experience of taking part in STEPPS-EI when living with emotional intensity difficulties was embedded in 'an emotional journey'. This formed a superordinate theme that was set within narratives of distress relating to help seeking, managing the therapeutic process and coming to an end with the intervention.

As people sought help and came to be referred to STEPPS-EI, they engaged with the group and faced a therapeutic milieu that was not as expected. This was in the face of experiencing emotion dysregulation without adaptive coping skills and reflects the difficulties people with

emotion regulation have in achieving goals that are mood dependent (Neacsiu et al., 2014). Despite the emotional challenges people were committed to continue the therapeutic process. The themes around engagement and persevering with emotion regulation skills groups is also present for people with BPD who report being worried about being judged by others and having to re-commit themselves to persevere through their difficulties (Barnicot et al., 2015). The ending of STEPPS-EI appeared to be emotionally crucial with some people moving through this with difficulty. Yalom (1985) suggests the ending re-enacts previous painful endings and losses. For people with emotional intensity difficulties this may lead to feelings of rejection and abandonment linked to difficult childhood experiences (Katsakou et al., 2012).

Emotional intensity difficulty is not a diagnostic category and within STEPPS-EI this appeared to leave some people with feelings of uncertainty about what difficulty they were journeying with. The diagnostic system does not yet conceptualise BPD on a continuum where people with less severe traits are included, which may create uncertainty around communicating this (Livesley, 2018). However, similar issues were experienced by people with BPD where diagnosis was reported to be withheld and not properly explained (Bonnington & Rose, 2014). This could be linked to the difficulties experienced by mental health professionals in responding therapeutically and may include communicating effectively about diagnosis (Commons Treloar & Lewis, 2009). Some people felt that problems in regulating emotions would lead to further challenges in the future, which is also an issue for those who live with a diagnosis of BPD and suggests it is an ongoing journey (Katsakou et al., 2012; Little et al., 2018). This reflects the heightened physiologically emotional sensitivity experienced by people with a diagnosis of BPD, which continues be a part of their lives following skills training (Crowell et al., 2009). Interestingly, the word ‘recovery’ has been described as unhelpful as it encourages a ‘black and white’ perspective

which is often a problematic issue when living with BPD (Katsakou et al., 2012; Linehan, 1993). The expectation of more challenges ahead may also suggest insufficient time available to embed skills. The information processing model proposes that regulation requires the ability to implement strategies to manage emotions at various points of emotion generation process (Gross, 2014). A theme of commitment and recommitment has been described by people with BPD in a year-long treatment where skills were practised until it became an automatic response (Barnicot et al., 2015).

People's emotional journey became shared with group members and facilitators. The superordinate theme of 'developing relationships' was idiosyncratic and described a range of experiences specific to individuals. The trust in facilitators was varied with some people feeling apprehensive about their competencies in managing the group environment. The alliance with the group therapist has been shown to have a stronger link to outcome than the overall group cohesion (Marziali, Munroe-Blum & McCleary, 1997). People were different in their capacity to trust other group members and some individuals found it difficult to connect with others. The role of facilitators has been described as important within DBT skills training groups as they ensure everybody gets involved and keep the meeting focused (Cunningham, Wolbert & Lillie, 2004). This suggests the ability of individuals to engage with each other and feel a cohesive environment may be dependent on the facilitation of the group environment. These issues appear to reflect the complex nature of managing groups with people who experience emotion dysregulation (Sagen Inderhaug & Karterud, 2015).

A superordinate theme around group members 'developing and understanding themselves' emerged as they came to understand their experiences of emotional dysregulation. The commonality of having emotional intensity difficulties helped feelings of normality as people started to understand their own behaviours. Understanding and labelling emotions is important in order to implement strategies to achieve a desired outcome (Gross, 1998). For

those with BPD the shared experience of emotion dysregulation is a central theme when they discuss their progress within skills training groups (Little et al., 2018). This seems to reflect an important feature of group therapy where group members provide a 'mirroring' function that enables people to see parts of themselves reflected in others (Wright, 1989; Winnicott, 1967). People with emotion dysregulation and BPD have reported that improving relationships is an important part of their recovery (Katsakou et al., 2012). Participants were able to develop skills in emotion regulation and enabled change in relationship outside of the group. This required a complex range of skills that have been identified within the information processing model of emotion regulation, such as changing attention and cognitions when experiencing intense emotions in order to alter the response to important others (Gross, 2014). This is similar to experiences in DBT where improved relationships were reported by women with BPD and suggests that STEPPS-EI is able to support people on their journey with emotional intensity difficulties. (Cunningham et al. 2004; McSherry et al., 2012). The sense of agency is core within emotion regulation and the development of emotional awareness and strategies helped participants to feel empowered and hopeful about personal change (Gross, 2014). People with emotion dysregulation have difficulties in maintaining goals when experiencing negative emotions, and strategies to manage this open the opportunity to work towards goals (Neacsiu et al., 2014). Ridgway (2001) identifies similar themes in people's accounts of recovery from mental health difficulties, including understanding of difficulties, developing hope, actively coping and gaining a positive sense of self. However, living with intense emotions as a positive part of self was identified as absent from STEPPS-EI.

Limitations

The IPA of the interviews and interpretations were made primarily by the researcher, which means the findings may not be exhaustive with the possibility of further themes being

perceived by others. While theme development was carried out in collaboration with a supervisor to increase rigour, the use of an additional researcher to analyse the data would add to the objectivity.

Participants were not asked to give detailed demographic information. However, this would be valuable in situating the results as a theme around difference emerged. Unfortunately, it was not possible to collect this information when this became apparent due to practical and ethical reasons around contacting and re-engaging participants.

Clinical implications

Greater attention to people's emotional journey and anticipation of group therapy may prevent adding to their distress as they engage with STEPPS-EI. Information around what to expect may help people to manage the emotional experiences and tasks likely to be encountered in joining and participating in the group, as emotion dysregulation makes it problematic to achieve goals (Neacsiu et al., 2014). This would prepare people and also ensure a fuller consent to therapy.

The facilitators have an important role in managing the group tasks and need to attend to issues around difference as this appeared to impact negatively on some participants' experiences (Cunningham et al., 2004). A focus on this would enable facilitators to establish a stronger group cohesion.

Some participants felt STEPPS-EI was not suitable, but it was offered as nothing else was available. This may reflect a service level problem. Therefore further interventions may need to be developed to meet the need of people coming into IAPT services with emotional intensity difficulties.

The ending of STEPPS-EI requires careful management by facilitators to address individuals' ongoing needs. Offering a monthly drop-in group where people can come to review their

progress could potentially cover this demand and support people to embed the emotion regulation skills. Greater attention to the risk of the ending re-enacting rejection and abandonment may ensure individuals are engaged to work through these issues with the service instead of being left to manage increased distress on their own (Yalom, 1985).

Research Implications

Research into the effectiveness of STEPPS-EI is required as this programme is only in its infancy and a randomized controlled trial is needed to assess its efficacy. Further qualitative research investigating service user experiences of the intervention and therapeutic process will support facilitators in managing relationships with group members and within the group. A particular focus on endings is essential as there is little research exploring how this transition is managed well which appears particularly important for people with emotional intensity difficulties (Shapiro & Ginzberg, 2002).

The absence of clarity around the definition of subthreshold BPD and emotional intensity difficulties shows further research and theory development is needed to develop a clearer understanding of this.

Conclusions

This study used IPA to explore the ways in which people with emotional intensity difficulties experience relationships within STEPPS-EI as well as the impact on their relationships outside the group. People's experiences of managing distress and shame, engaging with therapy, persevering, adjusting and coping with the ending were embedded within their ongoing emotional journey. For most people, the supportive and accepting group environment enabled the development of an understanding of themselves. Additionally, for some individuals this led to developing the ability to regulate emotions while others went on

to develop skills in managing relationships. Within clinical practice a greater consideration of the individual's journey may avoid experiences of uncertainty around engagement with group therapy, adjusting to life with emotional intensity difficulties, group ending and the journey ahead.

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SECTION C: Appendices of supporting material

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

DECEMBER 2018

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A: Quality Assessment Tool for Quantitative Studies

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify _____
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):

1	**STRONG**
2	**MODERATE**
3	**WEAK**

Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended. Mixed methods studies can be quality assessed using this tool with the quantitative component of the study.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A study that uses observations at multiple time points before and after an intervention (the 'interruption'). The design attempts to detect whether the intervention has had an effect significantly greater than any underlying trend over time.
Exclusion: Studies that do not have a clearly defined point in time when the intervention occurred and at least three data points before and three after the intervention

Other:
One time surveys or interviews

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

Score **NOT APPLICABLE** if the study was a one-time interview or survey where there was not follow-up data reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Component Ratings of Study:

For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS

Good: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Fair: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).

Poor: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) DESIGN

Good: will be assigned to those articles that described RCTs and CCTs.

Fair: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: will be assigned to those that used any other method or did not state the method used.

C) CONFOUNDERS

Good: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1).

Fair: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2).

Poor: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

D) BLINDING

Good: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and** the study participants are not aware of the research question (Q2 is 2).

Fair: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2).

Poor: The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1); **or** blinding is not described (Q1 is 3 and Q2 is 3).

E) DATA COLLECTION METHODS

Good: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

Fair: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

Poor: The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:

Good: will be assigned when the follow-up rate is 80% or greater (Q1 is 1 and Q2 is 1).

Fair: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q1 is 4 or Q2 is 5.

Poor: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q1 is No or Q2 is 4).

Not Applicable: if Q1 is 4 or Q2 is 5.

Appendix B: Table of Study Quality Rating for Reviewed Studies

Study	Study design	Selection bias	Confounding variables	Blinding	Data collection Methods	Withdrawals	Intervention Integrity and Analyses	Study quality (EPHPP)	Primary outcome
Black et al. 2013	A cohort design within a prison setting STEPPS group (n=77) with pre- and post-intervention measures 20 week (120min) intervention delivered by therapists who had attended 2-day STEPPS training **Rating: Moderate**	77 people meeting DSM-IV diagnostic criteria assessed by psychiatrist and psychologist but not using formal diagnostic assessment tool 67 were enrolled in a STEPPS group taking place in an Iowa prison and 10 in an Iowa community corrections-based group Exclusion criteria were not recorded Pp were taking part in a STEPPS programme within and completing routine outcome measures that later has been enrolled in research **Rating: Moderate**	63 female and 14 male participants Age range: 19-50 *M*= 31.4 *SD*= 8.6 Demographic, social and clinical features were recorded but confounding variables were not controlled for **Rating: Weak**	Assessment were carried out by psychiatrist and clinical psychologists As the data was not collected for research purposes the participants are not likely to be aware of the research question Outcome measures were self-report measures **Rating: Moderate**	Data collection took place at baseline and week 4,8,12,16 and 20. Outcome measures: ○ BEST ○ PANAS ○ BDI **Rating: Strong**	There was a total of 47% drop-out For the prison setting there was a 39% drop-out all due to transfers within the prison setting For the community based setting there was 100% drop-out without a clear reason for this **Rating: Weak**	The consistency and adherence to the STEPPS model was rated for the first group in each prison setting with excellent adherence to the model ITT and clinical significance is not analysed A linear mixed-effects model was used to analyse outcomes. A logistic mixed-effects model was used to analyse suicidal behaviours and disciplinary infractions. **No rating required**	**Weak**	A linear mixed-effect model showed statistically significant improvement in BPD symptoms (BEST; Pfohl et al., 2009; F=78.1, df= 1, p<0.001, d=1.30) and depression symptoms (BDI; Beck, 1978; F=85.7, df=1, p<0.001, d=1.08). The effect sizes ranged between 0.69 and 1.3, suggesting a moderate to very large effect size There was a statistically significant improvement in suicidal behaviour (p=0.029) and disciplinary infractions (p=0.043). Predictors of improvement in BPD symptoms were a higher level of symptoms at the start of the intervention

Blum et al. (2002)	A pilot study using mixed design; including a cohort and a survey design STEPPS programme (n= 52) using repeated measures data at pre- and post- intervention 20 week group by therapists with master-degrees and trained in STEPPS A survey was posted to Pp and therapist following the intervention **Rating: Moderate**	52 people meeting DSM-IV criteria assessed through clinical interview and case note review Exclusion criteria not reported Pp recruited from university of Iowa and off-campus sites Recruitment method not reported For the survey 49 people were sent a brief mail survey with a 42% response rate **Rating: Weak**	49 women and 3 male participants within the cohort design Age range: 18-51 *M*= 37 *SD*= 8.1 No confounding variables were accounted for in the effectiveness study For the survey: Participants' age: *M*= 39 (SD 11) 89% Women Therapists' age: *M*= 45 (SD 10) 92% Women **Rating: Weak**	The assessment process was not reported as the data collection was part of routine clinical data collection **Rating: Moderate**	Data was collected prior- and post-intervention as well as BEST scores being collected weekly Outcome measures: ○ BEST ○ PANAS ○ BDI It was not reported when the survey was sent to PP **Rating: Strong**	Withdrawals and drop-outs were not reported in this study **Rating: Weak**	A repeated-measures analysis was used on all available data Effect sizes were included in the study, however, there was not ITT analysis or analysis of clinical significance **No rating required**	**Weak**	Participants had a statistically significant decrease in their BPD (Borderline Evaluation of Severity over Time, BEST, Pfohl et al., 2009; *F*= 2.10, *df*=18, 392, *p*=0.006, *d*=-1.10), and depression symptoms (BDI, Beck Depression Inventory, Beck, 1978; *F*= 2.04, *df*=18, 25, *p*=0.009, *d*=-0.78) There was a significant decrease in negative affect, but not an improvement in positive affect The effect sizes indicate a large effect size for BPd symptoms and negative affect. However, a moderate effect size for depression symptoms. The survey indicated Pp felt more skilled in managing their emotional states, however, people may not have noticed this The survey indicated therapists felt STEPPS was easy to understand and clients had learnt new skills, but there was too much material and sessions too long

Blum et al. (2008)	Randomised controlled trial (randomisation by coin toss) with controlled 12-month follow-up STEPPS group + TAU (n=65) Vs. TAU (n=59) TAU described as medication, individual psychotherapy and case management 20 weeks (1x120min) by clinical psychologists For STEPPS group a designated mental health professional and family member was required for the systems component **Rating: Strong**	165 people meeting DSM-IV criteria for BPD Exclusion criteria: Not speaking English, psychosis or primary neurological disorder, cognitive impaired, substance abuse/ dependence, participated in STEPPS previously Recruited from inpatient, outpatient services and mental health centres in Iowa through advertisement and word of mouth **Rating: Moderate**	103 female and 21 male participants 40 Pp did not receive their allocated intervention following assessment Age range: 18 and above *M*= 31.5 *SD*= 9.5 Confounders controlled for: Age, sex, medication, pre-intervention scores on BPD measures, avoidant personality disorder, individual psychotherapy, medication Medication use decreased for both interventions and individual psychotherapy remained static in both groups **Rating: Strong**	Assessors were intended to be blinded to conditions, but described as impossible **Rating: Weak**	Assessors had good interrater reliability. Outcome measures were collected at 4, 8, 12, 16 and 20 weeks. Follow-up data was gathered at 1, 3, 6, 9 and 12 months Outcome measures: ○ Zanarini Rating Scale for BPD ○ BDI ○ Positive and Negative Affect Schedule (PANAS) ○ Symptom Checklist 90-Revised ○ Barratt Impulsiveness Scale ○ Social Adjustment Scale ○ Clinical Global Impression ○ Global Assessment Scale **Rating: Strong**	25% of Pp's allocated to the STEPPS intervention did not receive the intervention This was followed by 5.2% Pp's dropping out of the STEPPS+TAU and 9% from the TAU	Treatment consistency was measured by rating video recordings showing a good consistency Pp were included who had one post baseline measure and age, gender, BPD and depression severity did not predict whether pp dropped out Data analysis was carried out using linear mixed-effects model and ANOVAS. Analysis showed no statistical differences between premeasures of those who dropped out compared to those who completed the intervention.	**Moderate**	Participants in the STEPPS-TAU group showed significant improvements in BPD symptoms (Zanarini Rating Scale for Borderline Personality Disorder (Zan-BPD); Zanarini et al., 2003; *F*=11.0; *df*= 1, 89; *p*=0.001; estimated effect size = 0.84) and depression symptoms (BDI; Beck, 1978; *F*=4.6; *df*= 1, 377; *p*=0.033; estimated effect size = 0.50) with rates of change greater than the TAU alone group. The treatment gains in the STEPPS+ TAU group was maintained at follow-up No statistical difference in level of time spent in hospital between the two groups There was a greater use of A&E visits by those who received the TAU intervention alone during the intervention and follow-up

Gratz & Gunderson (2006)	A small scale randomized controlled trial Emotion regulation group intervention + TAU (n=12) Vs. TAU on a waiting list to receive intervention (n=10) 14 weekly (90min) sessions delivered by the developers of the intervention Pp were also required to be receiving an individual psychotherapy **Rating: Strong**	22 people meeting DSM-IV diagnostic criteria for BPD Inclusion criteria: ○ 18-60 years ○ Scoring 8< on Revised Diagnostic Interview for Borderlines ○ History of deliberate self-harm (including the last 6 months) ○ Having a therapist Exclusion criteria: ○ Diagnosis of psychosis, bipolar disorder and/or substance misuse ○ High risk Suicide attempts ○ Greater than "some chance" of attempting suicide Recruited through referrals and advertisement in greater Boston **Rating: Moderate**	This intervention was delivered to women only Age range=19-58 *M*=33.32 *SD*= 9.98 Confounders controlled for: Hours of therapy, level of emotional dysregulation, number of lifetime events of self-harm, social demographics, number of psychiatric medications taken **Rating: Strong**	Assessments were carried out by research assistants who were aware of the research and allocation of participants, however, outcome measures were self-reports measures and this may therefore be less important for this study Participants were aware of the research question for the project **Rating: Weak**	Outcome data was collected at two weeks prior to the intervention starting and one week after completion Outcome measures: ○ Deliberate Self-harm Inventory ○ Difficulties in Emotion Regulation Scale ○ Acceptance and Action Questionnaire ○ BEST ○ Depression and Anxiety Stress Scale (DASS) **Rating: Strong**	8% drop-out from the research study with one Pp dropping out from each condition **Rating: Strong**	Analysis to determine treatment effects was completed using ANCOVAS (controlling for pre-treatment assessment scores) ANOVAS were used for within group analysis ITT analysis was not completed, however, there was a very low drop-out rate for this study Effect sizes and clinical significance was reported **Rating not required**	**Moderate**	Data analysis using ANCOVAS showed statistically significant improvements in emotion dysregulation (DERS; $F(1, 19)=22.66$, $p< 0.01$, partial $\eta^2= 0.54$), depression (DASS-depression; $F(1, 19)=7.99$, $p< 0.05$, partial $\eta^2= 0.30$), anxiety (DASS-Anxiety, $F(1, 19)=8.66$, $p< 0.01$, partial $\eta^2=0.31$), $p<0.01$) and BPD symptoms (BEST, $F(1, 19)= 9.63$, $p< 0.01$, partial $\eta^2= 0.34$), Analysis of clinical significance showed the following reliable improvements with Pp falling within the normative range: 50% for depression, 33% for anxiety, 67% for stress symptoms 42% of Pp in the treatment condition showed a 75% reduction in self-harm

Gratz & Tull (2011)	A cohort design ERGT+ TAU (n=23) using pre- and post- group measures 14 weekly sessions (90min) delivered by therapists trained for 4 months in ERGT 4-6 participants per ERGT **Rating: Moderate**	36 people offered to take part meeting full DSM-IV diagnosis or a subthreshold meeting one less criterion 36% of people declined to take part for various reasons Inclusion criteria: ○ Deliberate self-harm including previous six months ○ Having an individual mental health practitioner ○ 18-60 years Exclusion criteria: ○ Diagnosis of substance misuse, psychotic and/or bipolar disorder Recruited through referrals from clinicians and advertisement in greater Jackson Mississippi **Rating: Moderate**	The study only included women Age range=19-50 *M*=34.3 *SD*= 10.6 Confounding variables were not controlled for e.g. psychiatric medication or level of TAU **Rating: Weak**	Assessments were carried out by bachelor and doctoral level clinical assessors Assessors were not blinded to the condition as there was only one condition **Rating: Weak**	Data was collected one week prior- and one week post-group intervention Outcome measures: ○ Zanirini Rating Scale for BPD ○ BEST ○ Difficulties in Emotion Regulation Scale (DERS) ○ The Acceptance and Action Questionnaire ○ BDI ○ DASS ○ The Deliberate Self-harm Inventory (DSHI) ○ Borderline Symptom List-behaviour symptom list ○ The Sheehan Disability Scale (SDS) ○ The Quality of Life Inventory (QOLI) **Rating: Strong**	17.4% drop-out from ERGT **Rating: Strong**	Adherence to treatment protocols were reported by therapists and estimated to be very adherent to the treatment protocol ITT analysis completed ANCOVAS used to determine change over time for ITT sample and ERGT completer sample Clinical significance was analysed **No rating required**	**Weak**	Statistically significant changes for the group completer sample on Zanirini Rating Scale for BPD ($F(1, 18) = 16.80$, $p< 0.05$, partial $\eta^2= 0.48$), BEST ($F(1, 18) = 14.78$, $p< 0.05$, partial $\eta^2= 0.45$) and Difficulties in Emotion Regulation Scale ($F(1, 18) = 36.10$, $p< 0.05$, partial $\eta^2= 0.67$), DASS-Depression ($F(1, 18) = 24.40$, $p< 0.05$, partial $\eta^2= 0.58$) and DASS-Anxiety ($F(1, 18) = 7.20$, $p< 0.05$, partial $\eta^2= 0.29$) Participants reached ITT sample was highly consistent with the completer sample apart from anxiety symptoms. Pps reached normative levels of functioning and reliable change for DERS (57.9%), Zan-BPD (42.1%); BEST (26.3%), DASS-depression (21.1%) and DASS-Anxiety (10.5%).

Gratz, Tull & Levy (2014)	Randomised controlled trial with a 9-month uncontrolled follow-up (Pp allocated using a stratified randomisation procedure) Emotion Regulation Group Treatment +TAU (ERGT+TAU; n=31) Vs TAU waitlist (n=30) 14 weeks (90min) with max. 6 members in each group delivered by therapists trained in ERGT **Rating: Strong**	69 women meeting DSM-VI criteria for BPD or subthreshold (8 people offered a place declined to participate) Inclusion criteria: ○ Meeting threshold or subthreshold for BPD diagnosis ○ History of DSH with one episode in last 6 months ○ Having an individual therapist, psychiatrist or case manager ○ Being a woman aged 18-60 Exclusion criteria: ○ Diagnosis of psychosis, bipolar I disorder and/or substance dependence Pp's were referred by clinicians and self-referred through advertisements **Rating: Moderate**	61 female participants ERGT+ TAU age: *M:* 33.3 *SD*: 11.0 TAU waitlist age: *M:* 33.0 *SD*: 10.9 Confounders controlled for: Emotion dysregulation, number of lifetime incidents of DSH, GAF score and age The ERGT group had significantly lower scores on the DERS lack of clarity scale than the waitlist condition The waitlist condition received more individual therapy than the ERGT condition with no between group difference in the amount of therapy received **Rating: Strong**	Assessments were carried out by trained assessors who were not aware of the treatment conditions It was not possible for Pp to be blind to treatment condition due to the study design **Rating: Moderate**	Outcome measures were collected at 1 week pre-, 1 week post-, 3- and 9-month post-treatment Outcome measures: ○ Deliberate Self-Harm Inventory ○ Self-Harm Inventory ○ Zanarini Rating Scale for BPD ○ BEST ○ BDI ○ DASS ○ Inventory of Interpersonal Problems ○ Sheehan Disability Scale ○ Quality of Life Inventory ○ Difficulties in Emotion Regulation Scale ○ The Acceptance and Action Questionnaire **Rating: Strong**	A total of 23.5% of Pp dropped out of the clinical trial; 16.7% from ERGT+TAU group and 10% from TAU waitlist **Rating: Moderate**	Treatment adherence was measured and the process described which indicated an acceptable treatment adherence Latent growth models were used to analyse data, adopting a Bayesian approach Used a multiple imputation strategy to handle missing data which created an ITT sample The approach by Jacobsen and Truax (1991) was used to identify clinical significance **Rating not required**	**Strong**	Significant effects were found of ERGT on emotion dysregulation (DERS, Effect size=-0.55), BPD symptoms (ZAN-BPD, Effect size= -1.20; BEST, Effect size= 0.34), depression (DASS-Depression, Effect size= -0.51) and anxiety (DASS-Anxiety, Effect size= -0.38). 41.9% had clinical significant improvement in BPD symptoms and 35.5% in deliberate self-harm following the ERGT intervention; as well as 49% having clinically significant improvements in BPD symptoms and 43.1% in deliberate self-harm at 9-month follow-up

Linehan et al. (2015)	3-arm, single-blind randomized clinical trial with 1-year follow-up Dialectical Behavioural Therapy (DBT; Individual and group components; n=33) Vs. DBT- Skills group (DBT-S; DBT with skills group only+ case management; n=33) Vs. DBT- Individual therapy (DBT-I; DBT with individual therapy only+ social group; n=33) 1-year All participants were managed using the LRAMP All participants' medication was managed by a psychiatric nurse practitioner **Rating: Strong**	99 participants meeting DSM-IV diagnostic criteria for BPD Age range: 18-60 *M:* 31.1 *SD*: 8.2 Inclusion criteria: ○ 5 suicide attempts and/or NSSI in past 5 years ○ At least 1 suicide attempts and/or NSSI in the 8 weeks before study ○ At least 1 suicide attempt in the last year (Criteria relaxed due to problems) Exclusion criteria: ○ IQ less than 70 ○ Psychotic, bipolar or seizure disorder ○ Treatment of other life-threatening disorder Recruitment through healthcare practitioners **Rating: Moderate**	The study only included women Confounders controlled for: Age, no of suicide attempts, no of NSSI episodes, psychiatric hospitalisation in previous year, depression severity and medication **Rating: Strong**	Assessments were carried out by independent assessors who were not aware of the study condition allocated to participants It is not clear whether participants were aware of the research question **Rating: Strong**	Data was collected before treatment commenced, quarterly during one year of treatment and one year of follow-up Outcome measures: ○ The Suicide Attempt Self-Injury Interview ○ The Suicidal Behaviours Questionnaire ○ Reasons for Living Inventory ○ Treatment History Interview ○ Hamilton Rating Scale for Depression ○ Hamilton Rating Scale for Anxiety **Rating: ?**	The drop-out rate for each group was: ○ 8% DBT ○ 48% DBT-I ○ 39% DBT-S **Rating: Weak**	The risk management approach across conditions is an additional treatment Pp in standard DBT received significantly more individual sessions than Pp in DBT-S group; Pp in standard DBT and DBT-S received more group therapy than Pp in DBT-I ITT analysis was completed but clinical significance was not reported Method for measuring adherence to the DBT model not reported Mixed-effects modelling was used for data analysis with pairwise contrast to evaluate between-group differences **Rating not required**	**Moderate**	No differences between groups in suicide related outcomes including suicide attempt and NSSI acts at the one-year follow-up For A&E visits and hospital admissions there were no between group differences during the treatment year for psychiatric reason. At one-year follow-up fewer Pp in the DBT group had A&E visits or hospital admissions There were no between group differences for rates of visits to A&E or hospital admissions for suicidality There was a significant interaction between time and condition effects for anxiety ($F_{2, 399}$= 7.9, p= 0.001) and depression ($F_{2, 94}$= 3.4, p= 0.04), with greater improvements for standard DBT and DBT-skills group during the treatment year, whereas DBT-I had greater change in the follow-up year.

McMain et al. (2017)	Two-arm, single blinded randomised controlled trial (randomised using a standard random block design in blocks of four) DBT skills group (n=42) Vs. Waitlist (n=42) 20 week DBT skills group delivered by therapists experienced in facilitating DBT groups, therapists attended a weekly consultation DBT group attended a 90min introduction session Pp encouraged to have a crisis support network **Rating: Strong**	140 people were screened and 84 eligible Pp were enrolled Inclusion criteria: ○ Meeting DSM-IV criteria for diagnosis of BPD ○ 18-60 years ○ 2 Suicidal/ NSSI acts in past 5 years with 1 in the 10 weeks prior to intervention ○ Able to understand English Exclusion criteria: ○ Diagnosis of psychotic disorder, bipolar 1 disorder or dementia ○ Organic brain syndrome ○ Intellectual disability ○ Participation in DBT in past year Pp recruited from outpatient mental health centre in Toronto **Rating: Strong**	66 female and 18 male participants took part Age range: 18-60 *M:* 29.67 *SD*: 8.62 Group distribution were checked for non-normal distribution Confounding variables controlled/ accounted for: medication, demographics, NSSI behaviours, hospitalisation days & A&E visits No difference between groups between psychosocial treatments received, however group therapy was received by more Pp in DBT skills group (included DBT skills group intervention) **Rating: Moderate**	Assessors were blind to the treatment-condition while treatment history was taken by research assistants who were not blind to Pp conditions **Rating: Moderate**	Outcome measures were collected at baseline, 10 weeks, 20 weeks and 32 weeks (3-month follow-up) Outcome measures: ○ Lifetime Suicide Attempt Self-injury Interview (no demonstrated reliability/ validity) ○ Deliberate Self-Harm Inventory ○ Treatment History Interview ○ Borderline Symptom List-23 ○ State-Trait Anger Expression Inventory ○ Barret Impulsiveness Scale-11 ○ BDI-II ○ Social Adjustment Scale ○ DERS ○ Distress Tolerance Scale ○ Kentucky Inventory of Mindfulness Scale **Rating: Strong**	Dropout was defined as not attending 3 consecutive session or 5 sessions in total Drop-out rate was 31% for DBT skills group and 9.5% participants across both groups were lost to follow-up **Rating: Moderate**	Adherence rating was carried out on 10% of videotaped group session with Multilevel generalised linear models and Poissson distribution were used to analyse non-normally distributed outcome measures Multilevel linear growth curve models were used to analyse normally distributed outcome measures ITT sample was used for data analysis Clinical significance applied to SCLR-90, but not stat sig at follow-up **No rating required**	**Strong**	Statistically greater improvement were observed for the DBT-S group when compared with TAU on BPD symptoms (BSL, $p< 0.01$, d=0.32), symptom distress (Checklist-90-Revised (SCL-90-R); Derogatis & Melisaratos, 1983; $p<0.001$, d=0.41) and emotion dysregulation (DERS, $p< 0.001$; d=0.50) after the intervention, but not for depression (BDI, $p< 0.08$; d=0.32) or self-harm (DSHI, $p<0.09$). At the 32-week follow-up it was only emotion dysregulation that maintained statistical significance ($p<0.001$). Clinical significance and reliability was analysed for symptom distress (SCL-90-R) with no statistical difference between the groups at 32 weeks (DBT-S: 47.1% and 20.6%; TAU 41.0% and 20.5%)

Morton et al (2012)	Randomised controlled trial (Stratified randomisation based on presence/absence of two or more self-harm episodes in the last year) including a mediation analysis Acceptance and Commitment Therapy+ TAU (ACT+TAU; n= 21) Vs. TAU waitlist (n=20) 12 ACT sessions (120min) with 4-6 Pp in each group delivered by clinicians **Rating: Strong**	46 Pp were screened and 41 were included Inclusion criteria: ○ Four or more DSM-IV criteria of BPD ○ Seen in a mental health service responsible for crisis managed ○ Regular contact with a clinician Exclusion criteria: ○ Psychotic symptoms not associated with BPD ○ Threatening/ violent behaviours ○ Intellectual disability and cognitive impairment ○ Language barrier Pp recruited through referrals from clinicians from public mental health services in Melbourne **Rating: Strong**	38 female and 3 male participants CT+ TAU age: *M:* 35.6 *SD*: 9.33 TAU waitlist age: *M:* 34.0 *SD*: 9.02 Confounders controlled for: Demographics, BPD symptoms, and self-harm Pp's only differed on level of PTSD between groups with Pp in ACT+TAU group more likely to meet criteria for PTSD, but equal level of past trauma reported in both groups Not controlling for medication and hours of contact with professionals **Rating: Moderate**	The screening assessments were carried out by research assistants with clinicians carrying out clinical interviews prior to acceptance into the study Outcome measures were self-report measures It is not possible to tell whether assessors and participants were blinded to the conditions **Rating: Moderate**	Outcome measures were completed before first group session, after last group session and follow-up 13 weeks later Outcome measures: ○ BEST ○ DASS ○ Beck Hopelessness Scale ○ AAQ ○ Five Factor Mindfulness Questionnaire ○ Affective Control Scale ○ DERS **Rating: Strong**	A total of 22% from the research study with 7.3% from the ACT+TAU group and 14.7% from the TAU waitlist **Rating: Moderate**	There were no statistical difference between those who provided end-point questionnaires and those who did not Data was analysed using a mixed model procedures to help account for missing data A mediation analysis was carried out using boot-strapping to identify which variables mediated the outcome Consistency of the intervention delivery was not a measure, but treatment fidelity was reviewed Clinical significance was analysed **Rating not required**	**Strong**	Analysis showed improvement in emotion dysregulation [DERS estimate=-19.17, SE= 5.68, *t*(31.8)=-3.38, *p*=0.002, 95% CI: -30.74, -7.60, *d*=0.78], anxiety [DASS-A estimate= 7.90, SE= 3.36, *t*(32.0)=2.35, *p*=0.025, 95% CI: 1.04, 14.74, *d*=.83] and BPD symptoms (BEST [estimate= 9.71, SE= 4.21, *t*(32.5)=2.30, *p*=0.028, 95% CI: 1.13, 18.28, *d*=0.81] with 29% of participants showing clinically significant improvements in BPD symptoms . There were no significant changes in depression (DASS-D estimate= 6.51, SE= 3.93, *t*(34.6)=1.66, *p*=1.07, 95% CI: -1.47, 14.49, *d*=0.56]. Treatment gains were sustained at three months. Within a multiple mediation model emotion regulation (measured by the DERS) was the only mediator

Sahlin et al. (2017) **Country : Sweden**	Cohort design, uncontrolled open trial with 6-month follow-up 14 weekly sessions (120min) of ERGT (n=95) delivered by healthcare professionals with experience in CBT and who received a three-day training course on ERGT **Rating: Moderate**	108 women assessed Inclusion criteria: ○ Female ○ >18 years ○ Meeting DSM-IV criteria for diagnosis of BPD ○ 3 episodes or more of DSH in past 6 months ○ TAU in the community ○ No change in medication in the previous 2 months Exclusion criteria: ○ Diagnosis of psychotic/ bipolar I disorder ○ Substance dependence ○ Co-occurring disorders needing treatment ○ Unable to understand language spoken ○ Life circumstances interfering with attendance Participants recruited in outpatient	95 women took part Age range: *M*= 25.1 *SD*=7.0 Confounders controlled for: Medication status, TAU received and clinic where treatment was received **Rating: Moderate**	Participants were assessed by health care professionals in out-patient clinics This study was not blinded **Rating: Weak**	Data was collected at baseline, pre-treatment, post-treatment and 6-month follow-up using self-report measures completed on-line Outcome measures: ○ DSHI ○ DERS ○ BSL self-destructive behaviour supplement ○ DASS ○ Inventory of Interpersonal Problems (BPD-related composite) ○ Sheehan Disability Scales **Rating: Strong**	22% of Pp dropped out from the ERGT intervention **Rating: Moderate**	Treatment fidelity and consistency was reported Analyses completed in R using random effects modelling DSH frequency and BSL were analysed using negative binomial generalised mixed models and linear models were used for the continuous outcome measures An ITT sample was used for the analyses **No rating required**	**Moderate**	A significant 76% (95% CI 65 to 83) reduction in DSH was reported from pre-treatment to 6-month follow-up with a large effect size when comparing the means (d=0.99, 95% CI 0.70 to 1.30) For BSL a 35% (95% CI 20 to 46%) reduction was observed A large effect size was observe in the reduction on the DERS (d=1.03 (95% CI 0.69 to 0.89) and moderate effect size on the DSHI (*d*= 0.65, 95% CI 0.40 to 0.89) Small to moderate effect sizes were observed on the DASS (DASS-D, *d*=0.55, 95% CI 0.27 to 0.85; DASS-A, *d*= 0.25, 95% CI 0.01 to 0.49; DASS-S, *d*= 0.56, 95% CI 0.26 to 0.86)

		clinics taking part in the trial **Rating: Moderate**							

Shilling et al. (2015)	Randomized controlled trial Metacognitive training (B-MCT; n=22) Vs. Progressive muscle relaxation (PMR; n=26) Both group received eight sessions (60min) delivered over four weeks, both delivered by the same clinical psychologist Both groups continued with TAU during the group interventions **Rating: Strong**	48 people meeting DSM-IV diagnostic criteria for BPD within the age of 18-65 years Exclusion criteria: ○ Severe neurological disorder ○ Intellectual disability ○ Diagnosis of bipolar disorder, schizophrenia, dementia or substance dependence Pp's were recruited from an inpatient hospital in Germany. The recruitment method was not reported **Rating: Moderate**	44 female and 4 male Pp took part B-MCT age: *M:* 29.36 *SD*: 10.46 PMR age: *M:* 31.15 *SD*: 9.59 Confounding variables accounted for were: Demographics, IQ, BPD and depression symptoms Medication was not controlled for **Rating: Strong**	This study was not blind, but participants completed questionnaires anonymously **Rating: Moderate**	The outcome measure a self-report appraisal measure used to determine the acceptability of the group The validity and consistency of the measure has not been demonstrated **Rating: Weak**	Drop-outs were not reported **Rating: Weak**	An ITT analysis was not completed and clinical significance was not calculated Between-group *t*-tests were used to identify differences between the appraisal ratings **No rating required**	**Weak**	On the appraisal self-report measure Pp receiving B-MCT reported statistically significantly greater use of training, improvements in self-confidence, empathising, perspective taking and a decrease in symptoms when compared to reports by Pp receiving PMR

Shilling et al. (2018)	Randomised controlled trial with 6-month follow-up Metacognitive training (B-MCT, n=37) Vs. Progressive Muscle Relaxation (PMR, n=29) Both groups were twice weekly sessions (60min) for a period of 4 weeks All Pp continued with standard treatment which included DBT skills group, occupational therapy, physical therapy, medical visits, individual psychotherapy and medication **Rating: Strong**	90 people were assessed and eligible to take part with 16 people excluded Inclusion criteria: ○ 18-65 years ○ Meeting DSM-IV criteria for diagnosis of BPD ○ No substance dependence ○ No history of severe neurological disorder ○ No history of diagnosis of schizophrenia spectrum disorder or bipolar disorder Participants were recruited within an inpatient psychiatric hospital in Germany **Rating: Strong**	68 female and 6 male participants B-MCT age: *M:* 27.7 *SD*: 9.8 PMR age: *M:* 29.5 *SD*: 9.1 Confounders controlled for: demographics, length of service involvement, no of inpatient stays **Rating: Moderate**	Assessors were blind to participants' allocated condition It was not clear whether participants were blind to the research question **Rating: Moderate**	Data was collected at prior to first group session, after last group session and 6 months after group completion Outcome measures: ○ BSL short version ○ Zanarini Rating Scale (translated into German) ○ BDI **Rating: Strong**	Drop-out was not reported, but attendance of minimum 1 session B-MCT had 97% and PMR 80.5% attendance of minimum 1 session Mean no of sessions attended: B-MCT *M*= 5.00 (*SD*=1.07) PMR *M*=5.77 (*SD*=2.15) No statistical difference in attendance between the interventions Study completion was 73% at treatment completion and 65% at follow-up completion **Rating: Moderate**	Treatment fidelity was not reported Per-protocol and ITT analyses were carried out ANCOVAS were used for data analysis and the ITT sample was analysed using multiple amputation procedures Length of inpatient stay was not reported **No rating required**	**Strong**	No statistically significant group difference at the end of interventions At follow-up B-MCT Pp showed greater reduction in symptom severity compared to PMR on BSL with a medium to large effect size ($F(1,43)=4.679$, $p = 0.0310$, $\eta^2_{partial}=0.098$) and Zanarini Rating Scale ($F(1,38)=4.316$, $p = 0.045$, $\eta^2_{partial}=0.107$ At follow-up PMR Pp showed greater reduction in depressive symptoms on BDI ($F(1,43)=4.679$, $p = 0.0310$, $\eta^2_{partial}=0.098$) ITT analysis confirmed the results from the per protocol analysis results

Soler et al (2009)	Randomized, single-blind, two-group clinical trial (Blocks by four in SPSS utilised for randomisation) DBT skills training group (DBT-ST; n=29, based on skills training mode in DBT), delivered by CBT therapists trained in using DBT vs. standard group therapy (SGT; n=30, psychodynamic based) Both groups were 13 weeks (120min) All Pp reviewed bi-weekly by psychiatrist **Rating: Strong**	59 people meeting DSM-VI diagnostic criteria for BPD Exclusion criteria: Schizophrenia, drug induced psychosis, organic brain syndrome, substance dependence, bipolar disorder, intellectual disability, major depressive disorder, Clinical Global Impression of Severity less than 4 (Guy, 1976) and current psychotherapy Recruited from outpatients and emergency departments, recruitment procedures not reported **Rating: Moderate**	49 female and 10 male participants Age range 18-45 *M*= 28.45; *SD*=6.55 Confounders controlled for: Age, sex, medication, medication modification, pre-intervention scores on outcome measures **Rating: Strong**	Assessment carried out by psychiatrists who were not aware of treatment condition Pp requested not to discuss the intervention they received Pp not aware of which intervention was the treatment condition **Rating: Strong**	Data was collected prior to condition allocation by psychiatrists, however, the time at which pre and post intervention assessment is not reported Outcome measures: o Clinical Global Impression-borderline personality disorder o Hamilton Rating Scale-depression o Hamilton Rating Scale- Anxiety o Brief Psychiatric Rating Scale o Derogatis Symptom Checklist, Revised o Buss-Durkee Inventory o Barrat Inventory **Rating: Strong**	34.5% of Pps withdrew from DBT-ST group and 63.3% from SGT, with reasons for this reported. **Rating: Weak**	The consistency and adherence to treatment protocols of the interventions delivered were not measured Meeting with a psychiatrist every two weeks is an additional treatment Data analyses carried out on ITT sample and used Hierarchical Linear Modelling (HLM) Clinical significance is not analysed **Rating not required**	**Moderate**	DBT skills group had a higher retention rate (65.5%) than standard group therapy (36.6%). Pps in DBT-ST had greater improvement on Hamilton Rating Scale-depression (; $F(37.93)=4.59$, $p=0.001$) and Hamilton Rating Scale- Anxiety ($F(32.95)=2.90$, $p=0.018$) than SGT. Statistically significant improvements were observed for both DBT-ST ($p<0.001$) and SGT ($p<0.05$) on the Clinical Global Impression-borderline personality disorder, but no significant differences between the group outcomes ($p=0.218$). No between group differences were seen in A&E visits, self-harm or suicide behaviours.

William, Hartstone & Denson (2010)	Quasi-experimental controlled trial DBT skills group with Individual DBT (DBT-DBT; n=31) vs. DBT skills group with Individual TAU (DBT-S; n=109, TAU not defined but described as 'treatment with usual mental health professional') DBT skills group was 20 weeks (120min) delivered by clinical psychologists trained in DBT Non-specific telephone support available from the mental health service Number of therapy sessions offered to participants in each condition not recorded **Rating: Strong**	140 people meeting DSM-VI-TR diagnostic criteria for BPD were assessed Inclusion criteria: attending individual therapy, residence in service catchment area Exclusion criteria: psychotic illness, substance abuse, aggressive/ antisocial traits Group completion defined as: attendance of 70%, not missing more than 2 consecutive sessions, attendance of the final session. Pp were asked for consent to use data from the service for research purposes **Rating: Strong**	127 people consented to take part 68 completed the research: 13 males 55 females Age range 19-59 *M*=35.59 *SD*=10.02 72 people dropped out (attending at least one session): 7 males 65 females Age range 19-60 *M*=36.24 *SD*=11.16 Confounders controlled for: Age, sex, pre-intervention scores on outcome measures, service utilisation 6 months prior to taking part in the group **Rating: Strong**	The assessments were routine assessment as a part of service delivery Not possible to tell whether those carrying out assessments were aware of the group allocation or research question Not possible to tell whether participants were aware of the research question **Rating: Moderate**	Self-report measures were collected at first and final DBT group session Outcome measures: o The K10+ o The Behaviour and Symptom Identification Scale o The Beck Depression Index o The Borderline Syndrome Index (not a valid BPD measure) o The McLean Screening Instrument for Borderline Personality Disorder Level of service use information was collected for each participant from a database at 6 months prior to, during and 6 months after the DBT group **Rating: Strong**	32% Pp dropped out of the DBT-DBT intervention and 68% Pp dropped out of DBT-S intervention The reasons for Pp dropping out were not reported **Rating: Weak**	The consistency and adherence to treatment protocols for the DBT intervention was not measured or reported Only 51% received the DBT-DBT and DBT-TAU interventions The analysis was appropriate to the research design, however, the effects of drop outs on the final results were not considered. The study did not consider clinical significance No rating required	**Moderate**	Both DBT-DBT and DBT-S group completers reported a reduction in depression, anxiety and distress on self-report measures and inpatient days There was no main effect of type of intervention on psychometric measures. Those receiving DBT-S had large effect sizes for (McLean Screening Instrument for Borderline Personality Disorder (p<0.01, d=0.84) and BDI (p<0.01, d=0.77) and a small effect size for inpatient days (p=0.04, d=0.77). Participants in the DBT-DBT group had a higher intervention completion rate than those in DBT-TAU. They also had a statistically significant reduction in A&E visits.

References for reported outcome measures:

Beck Depression Inventory (BDI): Beck, A.T., (1978). *Depression Inventory*. Philadelphia, PA: Center for Cognitive Therapy.

Borderline Symptom List (BSL): Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R.-D., Domsalla, M., Chapman, A. L., Steil, R., Philipsen, A., & Wolf, M. (2009).The short version of the borderline symptom list (BSL-23): Development and initial data on psychometric properties. *Psychopathology*, *42*, 32–39. doi: https://doi.org/10.1159/000173701

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Appendix C: Outline of STEPPS-EI session content

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Appendix D: Participant information sheet

Title of Project: The relationship experiences in brief group therapy.

Researchers: Mrs Sabine Harland, Prof Tony Lavender and Ms Beverley Moss-Morris

Centre number: 1
Study Number: REC 184454
Participant Identification Number for this study:

Information about the research (part 1)

Hello. My name is Sabine Harland and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide to take part, it is important that you understand why the research is being done and what it would involve for you. You are welcome to talk to others about the study if you wish.

The information below tells you about the purpose of this study and what the process is if you decide to take part (part 1). More detailed information is available should you decide that you might like to take part in the study (part 2).

What is the purpose of the study?
The purpose of the study is to explore people's experiences of Systems Training for Emotional Predictability and Problem Solving – Emotional Intensity (STEPPS-EI), which is a brief group therapy. This includes looking at what it was like for people being in the group, meeting others with similar difficulties, and what this meant to them.

Why have I been invited?
You have been invited as you have recently taken part in a Systems Training for Emotional Predictability and Problem Solving – Emotional Intensity (STEPPS-EI) group within your primary care mental health setting.

Do I have to take part?
It is up to you to decide whether you would like to take part in the study. Your decision will not affect the standard of care that you receive.

What is the process if I take part?
If you agree that you would like to take part in the study, you will be invited to come for an interview with me. I can provide a map if you are not sure where these places are.

Before the interview I will ask you to sign a consent form, but you are free to withdraw from the study at any time, without giving a reason. This would not affect the standard of care you receive.

The interview will be about your experience of taking part in Systems Training for Emotional Predictability and Problem Solving – Emotional Intensity (STEPPS- EI). The interview will last 45-60 minutes and the whole process will take about 1 ½ hour in total. The interview will be audio recorded, which allows me to create a written version of the interview. This will be used to find similarities and differences in the experiences of people who took part in the group. Once these themes have been identified you will be invited to comment on whether it reflects your experience. The feedback will be considered to help reduce errors and researcher bias before the results are finalised.

Expenses and payments
You will receive £20 to cover any expenses you may incur.

What will I have to do?
Firstly contact me to arrange a time to meet. Then we will meet for an interview where I ask you about your experiences of participating in Systems Training for Emotional Predictability and Problem Solving – Emotional Intensity (STEPPS-EI), how you found being in the group and the impact on relationships within and outside of the group.

What are the possible disadvantages and risks of taking part
The aim of the study is not to explore previous upsetting experiences, but it is possible that the questions could lead to discomfort or distress for some people. I will help remind you of this before and during the interview. If for some reason you find the interview difficult or upsetting then you are able to withdraw from the process at any point.

What are the possible benefits of taking part?
We cannot promise the study will help you, but the information we get from this study may help improve the treatment of people who experience emotional intensity in primary care mental health settings.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. Further information about this is available in the more detailed information about the study (part 2).

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence (please see part 2).

If this has made you interested and you are considering participating in the study, then please read the additional information before making a decision (part 2).

Title of Project: The relationship experiences in brief group therapy.

Researchers: Mrs Sabine Harland, Prof Tony Lavender and Ms Beverley Moss-Morris

Information about the research (part 2)

What will happen if I don't want to carry on with the study?
If you decide to take part in the study, then you are able to withdraw from the study at any point, which includes before you take part in the interview, during the interview and after the interview has taken place. You can withdraw your interview from the research up until a month after it has been completed. The time limit is in place as the results will be written up for publication which will then prevent withdrawal from the study.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through Canterbury Christ Church University by contacting Paul Camic (Research Director) via email: paul.camic@canterbury.ac.uk or via post: Paul Camic, Salomons Centre for Applied Psychology, Canterbury Christ Church University, Runcie Court, David Salomons Estate, Broomhill Road, Tunbridge Wells, TN3 0TF.

You can also contact the Patient Liaison if there is a problem during or following the study to discuss your concern:

If you have any immediate concerns about your own well-being then please contact your GP or the mental health helpline.

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential. Your personal data will be numbered and once you have completed the interview this number will be attached to the audio-recording and written version of the interview. This means your interview is not easily linked to yourself, but this number means you can decide to withdraw from the study up to four weeks after the interview is completed should you decide you no longer want to take part.

Your personal information, your interview and the written version of your interview will be stored safely. All electronic storage will be encrypted which means it can only be accessed by people who have a password. Any paper copies will be stored in a locked cabinet.
The people who have access to your data are myself and supervisors involved in the current study. A third party will also help write up the audio-recordings, but this person will not have access to your personal details. People within regulatory authorities and the Trust Research and Development department may ask for access to the written version of the interview, which will be anonymous, in order to monitor and ensure the quality of the research.

The audio-recordings and personal information will be kept until the study has been completed and afterwards they will be securely destroyed. Your written version of the interview will be kept securely for the next 10 years so that it can be seen that ethical and research standards have been kept when carrying out the research, which is a part of the

Canterbury Christ Church University research policy. After this time it will be disposed of through secure methods.

Involvement of the General Practitioner/Family doctor (GP) or other services
Your GP and primary care mental health team will be notified of your participation in the current study. This is to ensure they are aware should you become distressed and contact them for further support following the interview. However, the interview itself is confidential and will not be shared with your GP or the primary care mental health team. Your decision to take part in the study does not affect the standard of care you are provided with.

In the event that I have concerns about the safety of yourself or others I will discuss these concerns with you. If there appears to be sufficient evidence to raise serious concern that yourself or others are at risk of immediate harm then I will liaise with necessary organisations such as emergency services. If there are other serious concerns such as involvement of possible harm to children or vulnerable adults then the police or social services will be contacted. Should these exceptional circumstances arise then they will be managed in accordance with the "Code of ethics and conduct" for Clinical Psychologists.

What will happen to the results of the research study?
The results from the current study will be shared within the NHS Trust. The plan is also for the study to be published within international journals. Your personal information will not be used for any of the publication or sharing of the results, however, anonymous quotes from the interviews may be used if you agree to this. Care will be taken to ensure any quotes used do not contain any information that can reveal your identity (e.g. detailed personal information or history). The results will be made available to you by e-mail or post. Please write your details on the 'consent form' if you would like to know the outcome of the current study.

Who is organising and funding the research?
This study is funded by Canterbury Christ Church University. The NHS Trust have a purely supportive role and is not funding this study.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been looked at and passed by East Midlands - Nottingham 1 Research Ethics Committee.

Further information and contact details
If you would like to speak to me and find out more about the study or have questions about it, you can leave a message for me on a 24-hour voicemail **phone line 0330117070. Please say that the message is for me, Sabine Harland, and leave a contact number** so that I can get back to you or you can e-mail me on **s.harland760@canterbury.ac.uk**. Further information will be available by contacting my supervisor Beverley Moss-Morris. Beverley will also be able to answer questions if you are unsure whether you should participate or if you are unhappy about the study.

Appendix E: The MacLean Screening Instrument for BPD

(Screening instrument for presence of DSM-IV BPD)

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Appendix F: Interview Schedule

Introduction

General Questions

Tell me a bit about how you came to be invited to take part in these groups…

- What happened that made you ask for help

Tell me what it was like being in a group for you…

- What thoughts or expectations did you have about the group before the first session?
- What was the first session like for each group?
- Does anything in particular stand out in your memory when you think about the group? Content/ Learning/ difficult interaction/ helpful/ relating to others

Group relationships

(Did you have the same group facilitators for both groups?)

What did you think or feel about the group facilitators?

- Was there anything they did that was particularly helpful/unhelpful?

(Were any of the group members from the first group with you in the second group?)

What was your experience of other people in the group?

- What was it like to hear about their difficulties?
- What was it like sharing your own difficulties?
- Were there any other aspects of what happened with other people in the group that were particularly helpful/unhelpful?

In what ways were the ways you thought/ felt/ experienced the facilitators and the group members similar or different?

In what ways were the relationships with/ what you thought or felt about the facilitators and other people in the group similar of different in terms of how the group functioned? (Question removed from interview)

Group process

Has the group been helpful in managing your emotions?

- How have your views of your emotions developed since taking part in the groups?
- Do you see/ understand yourself differently since you have taken part?
- How do you feel about these changes/how do you feel about things not changing?

Has the group changed the way you manage other aspects of your life?

- How have your views of how you manage things in your life developed since …
- How do you feel about these changes/how do you feel about things not changing?

Has the group impacted on your relationships with your family or close friends?

- Has what happened in the group helped your relationships with others?
- What do you think other people might have noticed since you have attended the groups?
- How do you feel about these changes/how do you feel about things not changing?

How did you experience the ending of the group/s?

- What was difficult?
- Was there anything that made it easier?
- Is there anything you would change about the way the group ended? (Question added to interview)

Closing

Appendix G: Interview Transcript

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Appendix H: Emerging Themes and Quotes

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Appendix I: Superordinate themes, themes and emergent themes example

Overall Theme	Emerging theme cluster	Emerging theme
Managing emotional distress	Ongoing emotional difficulties	Ongoing emotional difficulties
	Lack of alternatives when people feel it isn't working	Lack of alternatives when people feel it isn't working
Managing expectations and engagement	The description of STEPPS felt like it was relevant	Curious about STEPPS potential for being helpful
		STEPPS sounded manageable and relevant
	Apprehensive about attending group	Apprehensive about group therapy as previously unhelpful
		Apprehensive about engaging socially in a group environment
Persevering in the face of emotion dysregulation	Frustration with slow progress	Frustrating to see others progress quickly when this is not shared
		Felt frustrated and guilty about slow progress as felt like hadn't worked hard enough
		Sometimes difficult to apply skills learning to real life situations
Ending as emotionally crucial	Attending the friend and families evening made the ending easier	Attending the friend and families evening made the ending easier
	Reassuring to know there is further help if needed	Reassuring to know there is further help if needed
	A loss of routine/ having a group to go to	A loss of routine/ having a group to go to
Further challenges ahead	Prepared to persevere with skills to see further improvements	Prepared to persevere with skills to see further improvement
Developing trust with group members	Felt comfortable in the group	First session felt gentle without a pressure to talk

		Being with other socially confident group members made her feel more comfortable and confident
		Spoke up when she felt the need to
	Difficulties sharing personal issues	Found it difficult to know when to share experiences
		Found it difficult to share personal issues in a group
Coping with difference	Appreciated the range of people affected by emotional intensity	Appreciated the range of people affected by difficulties in similar ways
Developing trust with facilitators	Trusted the facilitators	Facilitators were respectful of individual differences
		Facilitators were caring towards group members
		Trusted the facilitators
Shared experience helped understanding of self	Found it easier to understand emotional intensity when shared through people's stories	Found it easier to understand concepts of feelings embedded in embedded in peoples' stories
	Reassuring to find shared experience	Reassuring to be with a group of people with similar struggles every week
		Felt like the group was in the situation together
	Shared experience of emotional intensity helped feeling 'regular'	Feels like a regular person rather than a broken person
		Felt she fitted in as other people were nervous too
Developed awareness and ability to manage emotion dysregulation	Developed the ability to manage behaviours and life despite intense emotions	Given names for abstract feeling helped her own understanding and ability to explain it to others
		Don't catastrophize feelings despite them still being intense

		Helped her ability to communicate with partner
		Being able to communicated about feelings has helped them not taking over
		Been able to cope with stressful work and life
Developed skills in managing relationships	Became socially more confident	Attending the group has made it easier to talk to people on the internet
		Hearing other people sharing experiences helped overcome anxiety about speaking up
	Developed the ability to be assertive	Dad's noticed she's more assertive and positive
		Terrifying to challenge others but prevents emotional difficulties
		Been able to challenge other people's negative thoughts
Developed agency and capacity to change	A framework that values lived experience	Liked the idea of STEPPS as a framework supported by people's lived experience
		Found the group more comfortable and easier to speak up with equal facilitators
		Liked the facilitators were presented as equals
		Facilitators directed the group but allowed the group to experience the course on their own terms
	The individuals existing skills are values	Liked the concept of having the means to help herself but not knowing how
		Feel empowered to manage her emotions
		Felt empowered by knowing she has the skills to manage, she just has to learn how
	Felt empowered to support others	Feel more confident in supporting other people with difficulties

	Developed hopefulness through noticing change in self and others	Felt hopeful when seeing other people progress
		Felt hopeful when hearing other people's abilities to persevere through adversity
		Reassuring to see people work through the therapeutic process at different stages
		Hopeful about the opportunity for further + progress
		Feels hopeful about her ability to continue to progress
		Encouraged to appreciate the small changes

Appendix J: Summary of results for respondent validation

The experience of taking part in brief group therapy (STEPPS-EI) when living with emotional intensity

Dear Participant,

I am writing to give a summary of the findings of the research project you kindly gave an interview for back in 2016/2017. Your participation has been invaluable and thank you again for taking the time to share your experiences with me. Below, I give a very brief summary of the findings. You are welcome to comment on these or ask questions if you should wish to and my contact details can be found at the end of the summary.

Summary of findings

The interviews were typed up and read multiple times to find themes within them. There were three overall themes for participants, which were as follows: an emotional journey, developing and understanding self, and developing relationships. Within the themes a further 18 subthemes were identified and these are listed in the summary below.

An emotional journey

There was a theme around the emotional journey with participants coming from a place of distress when seeking help, then engaging and persevering with therapy, followed by looking to the future. The following seven subthemes came through the participants' description of this journey:

- Managing emotional distress
- Managing shame and stigma
- Managing expectations of therapy
- Persevering in the face of emotional intensity
- Revising understanding of emotional world
- Ending as emotionally crucial
- Further challenges ahead

Developing and understanding self

Through their journey, most participants began understanding and developing a sense of themselves living with emotional intensity. Within this theme there were three subthemes about the way in which people felt they changed through STEPPS-EI:

- Shared experience helped understanding of self
- Developed awareness and ability to manage emotional intensity
- Developed understanding of own ability to change

Developing in relationships

The emotional journey took participants through STEPPS-EI alongside other group members. This led to a theme around participants' experiences with relationships with group members, facilitators and people in their lives outside of the group, which were covered in the following five subthemes:

- Developing trust with group members
- Coping with difference in the group
- Developing trust with facilitators (people running the group)
- Questioning facilitator competence
- Changes to relationships with people outside the group

Please feel free to contact me if you would like to share your thoughts about these themes or if you have any more questions about this study.

E-mail: s.harland760@canterbury.ac.uk
Address: Salomons Centre for Applied Psychology, 1 Meadow Road, Tunbridge Wells, Kent, TN1 2YG.

Thank you again for your time and attention.

Best wishes,

Sabine Harland

Complaints procedure: If you are at all dissatisfied with the conduct of this research please first contact the researcher (s.harland760@canterbury.ac.uk, Tel.: 01227 92 7166). If you still wish to complain about any aspect of the research project, please contact Professor Paul Camic, Research Director, Dept. of Applied Psychology, at paul.camic@canterbury.ac.uk or on 01227 92 7166. Canterbury Christ Church University is the sponsor of this research and is therefore responsible for its conduct. If you feel that you have been harmed by this research please contact Professor Paul Camic and he will discuss with you the complaints process of the university.

Appendix K: Reflective diary and bracketing interview

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Appendix L: Health Research Authority Approval

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Appendix M: NHS trust Research and Development approval

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Appendix N: Participant consent form

Title of Project: The relationship experiences in brief group therapy.

Researchers: Sabine Harland, Tony Lavender and Beverley Moss-Moriss

Centre number:
Study Number:
Participant Identification Number for this study:

Consent form

Please initial each box to show you agree with each statement

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care or legal rights being affected. ☐

3. I understand that a third party, who does not have access to my personal details, may help write up the audio recordings collected during the study. I also understand that audio recordings and anonymous written versions of the interviews will be accessed by the research supervisors, Ms Beverley Moss-Morris (Clinical Psychologist) and Prof Tony Lavender (Pro Vice-Chancellor Research and Knowledge Exchange). ☐

4. I agree to my interview being audio-recorded. ☐

5. I agree that in the event where there are serious concerns about my own or other peoples' safety these will be discussed with myself and if necessary services will be contacted that can manage the risk in accordance with the "Code of ethics and conduct" for Clinical Psychologists. ☐

6. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐

7. I agree to take part in the above study. ☐

8. I agree to be contacted to give feedback regarding the initial findings of the study. ☐

Please turn over to sign.

Name of Participant: _____ Date_____

Signature: _____

Correspondence address/e-mail:_____

_____

Please tick if you would like a copy of the final findings ☐

Support contact: _____

Contact no:
_____

GP:_____

_____

Name of Person taking consent: _____ Date_____

Signature: _____

Appendix O: Letter to GP and service

Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells
Kent
TN3 0TF

Address

Date

Dear xx

RE: patient

I am writing to inform you that one of your patients, **(patient)**, have taken part in a research project which looks at their experience of a new brief group therapy called Systems Training for Emotional Predictability and Problem Solving –Emotional Intensity (STEPPS-EI). This is a newly developed therapy in primary care mental health settings.

The patient has been interviewed about their experience of taking part in the group, their relationships within the group and also their relationships to family and friends. The aim of the study is not to explore previous upsetting experiences, but it is possible that the questions could lead to discomfort or distress for some people. The patient has been advised that they should contact their GP in the event they become distressed following the interview. Please see the attached information sheet for further information, which includes contact details should there be concerns about the study.

Yours sincerely,

Sabine Harland

Trainee Clinical Psychologist

Appendix P: Author guidelines for Clinical Psychology and Psychotherapy

PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

File types

Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

New Manuscript

Non-LaTeX users: Upload your manuscript files. At this stage, further source files do not need to be uploaded.
LaTeX users: For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

Revised Manuscript

Non-LaTeX users: Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.
LaTeX users: When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Abstract, Key Practitioner Message and keywords;
8. Main text;
9. References;
10. Tables (each table complete with title and footnotes);
11. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship
Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

Acknowledgments
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement
Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the Conflict of Interest section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract
Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner MessageAll articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords
Please provide five-six keywords (see Wiley's best practice SEO tips).

Main Text

1. The journal uses US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References
References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the APA FAQ.

Reference examples follow:

Journal article
Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi: 10.1176/appi.ajp.159.3.483

Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document
Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

Endnotes
Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures
Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.
Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices
Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

2. **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, authors may benefit from referring to Wiley's best practice tips on Writing for Search Engine Optimization.

Editing, Translation, and Formatting Support: Wiley Editing Services can greatly improve the chances of a manuscript being accepted. Offering expert help in English language editing, translation, manuscript formatting, and figure preparation, Wiley Editing Services ensures that the manuscript is ready for submission.

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Appendix Q: End of study form

This has been removed from the electronic copy.

Appendix R: Feedback summary for ethics panel and R&D

Summary

The experience of taking part in brief group therapy (STEPPS-EI) when living with emotion dysregulation: An interpretative phenomenological analysis

Background and aims

People with emotional intensity experience increased negative emotions and difficulties regulating their emotions without meeting the threshold for a borderline personality disorder diagnosis. Managing group relationships with a population that experience emotion dysregulation has been linked to chaotic group environments. This study explored the experiences of people living with emotional intensity and their relationship to other group members and facilitators within STEPPS-EI. It also looked at any other meaning the group may have and the impact on people's existing relationships.

Design and method

A qualitative approach using interpretative phenomenological analysis (IPA) was utilised to explore the idiographic understanding of participants' experiences. 10 participants were recruited through a NHS trust delivering STEPPS-EI and interviewed using a semi-structured interviews. These were subsequently transcribed and analysed using IPA.

Results

There were three superordinate themes for participants, which were as follows: an emotional journey, developing and understanding self, and developing relationships. Within the themes a further 18 subthemes were identified and these are listed in the summary below.

An emotional journey

There was a theme around the emotional journey with participants coming from a place of distress when seeking help, then engaging and persevering with therapy, followed by looking to the future. The following seven subthemes came through the participants' description of this journey:

- Managing emotional distress
- Managing shame and stigma
- Managing engagement and expectations of therapy
- Persevering in the face of emotion dysregulation
- Revising understanding of emotional world
- Further challenges ahead
- Ending as emotionally crucial

Developing group relationships

The emotional journey took participants through STEPPS-EI alongside other group members. This led to a theme around participants' experiences with relationships with group members and facilitators, which were covered in the following four themes:

- Developing trust with group members
- Coping with difference in the group
- Developing trust with facilitators
- Questioning facilitator competence

Developing and understanding self

Through their journey, most participants began understanding and developing a sense of themselves living with emotional intensity. Within this theme there were four themes about the way in which people felt they changed through STEPPS-EI:

- Shared experience helped understanding of self
- Developing awareness and ability to manage emotion dysregulation
- Developing agency and capacity for change
- Developing skills to manage relationships

Conclusion

The findings suggest individuals living with emotional intensity are on an ongoing emotional journey and experiences within STEPPS-EI becomes a part of this. Relationships within the group environment were impacted by differences between group members and linked to both positive and negative experiences and requiring management by group facilitators. Joining the journey of other group members appeared to improve people's understanding of themselves, their ability to regulate emotions and the relationships with others.