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STEPPS Group Treatment for Borderline Personality Disorder in The Netherlands

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Background. *Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a new cognitive group treatment for outpatients with borderline personality disorder.*
Methods. *The English and Dutch language literature was reviewed on the STEPPS program.*
Results. *STEPPS was introduced in The Netherlands in 1998 under the acronym VERS. Reasons for its rapid dissemination throughout Holland include a user-friendly manual, its 20-week duration, ability to maintain the patient's current treatment team, and ease of therapist training. Two pilot studies, one in the US and one in The Netherlands, suggest its efficacy. Randomized controlled trials are now underway.*
Conclusions. *STEPPS has become widespread in The Netherlands, and is now being modified for other settings, such as programs for adolescents.*

Keywords STEPPS, Borderline personality disorder, Cognitive-behavioral therapy, Family systems

INTRODUCTION

Borderline personality disorder (BPD) is a major health problem that is highly prevalent in the general population, significantly impairs quality of life, increases health care utilization, and leads to suicide in some persons (1,2). Despite the development of practice guidelines, there has been relatively little consensus among experts regarding treatment (3). Medication generally provides unsatisfactory results, and effective psychotherapy is often unavailable, inaccessible, or impractical. Further, few psychotherapies have been developed for BPD that have empirical support.

In this article, we describe a new cognitive-behavioral group treatment, now supported by two pilot studies. Though developed in the U.S. Midwest, it has emerged as the predominant group treatment model for BPD in The Netherlands. The reasons behind this phenomenon are explored herein.

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History of STEPPS

In 1995 one of the authors (NB) learned of a small outpatient program in Wheaton, Illinois at the DuPage County Health Department led by Norm Bartels (4), who had created a systems approach to treatment for BPD. The goal of this program was to teach emotion management and behavioral skills to patients with BPD, but also to teach and train key members of their support network to use a consistent approach and language with the patient.

At the time, the Iowa group were making plans to set up an outpatient group treatment program for patients with BPD and were looking at different models, while seeking to implement a program that might reduce health care utilization (e.g., hospital stays, emergency room utilization, clinic visits), and the many

behavioral problems associated with BPD, such as self-harm and suicide threats. There was also pressure from third-party payers to improve outcomes. Borderline patients were receiving outpatient medication management and psychotherapy combined with periodic hospitalizations, the latter prompted mainly by suicidal behaviors or threats.

The Iowa group modified the Bartels and Crotty program, which combined psychoeducation and cognitive-therapy techniques. What set it apart from other models was its systems approach, which meant that Bartels and Crotty understood that helping borderline patients involved more that just the identified patient, but those around him or her as well. This approach derives from family systems theory developed by Minuchin (5) and others to deal with dysfunctional family structures.

There were few existing treatment models at the time. Dialectical Behavior Therapy (DBT), developed by Linehan (6), was available and had many appealing features, in addition to empirical support. Nonetheless, there were several impediments to implementing it in Iowa, and it was decided that the Bartels and Crotty model was a better fit. Because of Iowa's frequently poor winter weather and rural location, it was thought that the length of DBT (1 year) was too long, and that a shorter program would work better. DBT would require special training, and would be more labor intensive than the Bartels and Crotty model because of its length, and the requirement for therapists to meet weekly. The potential difficulty in training therapists to administer DBT at the many small mental health clinics in Iowa and the higher upfront costs were also problematic. Further, the Iowa group felt any new program should employ general psychotherapy principles that therapists from widely different backgrounds would understand. Finally, the requirement that borderline patients in DBT also receive individual therapy with DBT-trained therapists was thought not to be feasible. Not only would it be difficult in rural Iowa to find such therapists, but there was a concern with the problem of separating emotionally fragile patients (who often fear abandonment) from their current treatment team.

The original Bartels and Crotty workbook consisted of 75 pages; a 225-page supplement was added, and later, at the suggestion of Norm Bartels, the two manuals were combined. The STEPPS manual continued to be refined over the first two years, creating new patient agendas and corresponding lesson plans, and modifying course content (7). In developing the treatment program, the Iowa group felt that a catchy, but descriptively accurate acronym would be useful. One of the authors (BP) coined STEPPS, which stands for Systems Training for Emotional Predictability and Problem Solving. The idea is that patients help themselves one step at a time, rather than attempting major leaps. Underlying STEPPS is the belief that BPD reflects a defect in the individual's internal ability to regulate emotional intensity, and that the inability to fully regulate emotional intensity is responsible for many of its manifestations (7,8). For this reason, BPD was reframed as a "disorder of emotional intensity." Emotional upheavals can lead to frequent mood swings, anger outbursts, and deliberate self-harm. There are interpersonal costs as well, as the emotional outbursts disrupt relationships, interfere with work productivity, and lead to frequent outpatient clinic visits and hospitalizations.

Two new scales were developed to use with the treatment manual. Their purpose was to 1) provide feedback about patient progress, and 2) provide feedback to patients. The first instrument was the Emotional Intensity Continuum (EIC), which is a Likert-like scale used to rate degree of emotional intensity currently being experienced by patients. This cross-sectional measure has five anchor points, ranging from 1, indicating calm, to 5, indicating feeling out of control. At a patient's suggestion, the EIC is now visualized as ranging from 1, a pot of cool water with no heat under the burner, to 5, the pot boiling over. At each weekly lesson, patients are asked to indicate the percent of time they spent at each level in the previous week. The Borderline Estimate of Severity over Time (BEST) was created for the professional (and the patient) to track severity and change. This is a 15-item self-report measurement designed to tap BPD symptoms. The scale ranges from 12 to 72, but patients entering STEPPS generally score in the 55 to 65 range. Preliminary data show that the scale has good internal consistency and is sensitive to change (7).

The STEPPS model involves making patients more aware of their disorder, and teaching them specific skills to help manage their emotions and behaviors (8). As part of increasing their awareness, the DSM-IV criteria are reviewed and patients are asked to acknowledge their symptoms and give examples from their life. This is referred to as "owning the illness." Illness awareness is also extended to the patient's support network, so that family members, for example, can benefit from learning about BPD.

Emotion management training involves teaching the borderline patient specific skills to help control the cognitive and emotional symptoms of the disorder. With behavior management training, there are seven behavior skill areas for the patient to master (8). Each session (or "class") in the 20 week program is organized around a specific lesson or skill; some skills require several sessions. As an example, one important component of behavior management involves learning to avoid self-destructive behavior.

The structure of the groups is such that the group spends little time focusing on the problems of particular patients. Instead, the group provides a format in which to acknowledge problems and offer support, but sets limits and boundaries on such interactions. Our goal is to teach patients to "focus on the disorder, not the content." Potential attendees are screened to ensure that they have BPD. Attendees need to understand that limits will be set regarding discussion of their own problems, and their need to maintain focus on the lesson plan.

Patients with prominent antisocial and narcissistic traits may not be well suited to the groups, nor are those who are prone to violent or intimidating behavior toward others. Groups have included both men and women, though it is thought that having at least two men in a group is preferable to

having only one. Both can provide support for one another, and reduce perceptions by the women that the single man represents the views of all men. Substance abusing patients are required to get that problem under control before entering STEPPS, or to be in treatment concurrently because substance abuse can actively interfere with their ability to cooperate and focus on the lessons.

Introduction of STEPPS in The Netherlands

STEPPS was introduced in The Netherlands by one of the authors (NB), who was invited in January 1998 to conduct workshops at two mental health clinics, one located in Deventer (60 km east of Amsterdam) and the other in Groningen, in the northern part of the country. Several Dutch mental health professionals had been in attendance when NB described STEPPS at a meeting in Vancouver, British Columbia in 1997, and believed the program would suit their needs. Since 1998, nearly 400 therapists have been trained in its use and administration, and it is now estimated to be used by more than half of all Dutch BPD treatment programs. This is not meant to imply that DBT is unavailable in Holland; DBT groups are available, as are DBT-trained therapists, and Verheul et al. (9), at the University of Amsterdam, recently conducted a randomized trial in which DBT was compared to usual treatment. The group receiving DBT showed better retention rates and less self-harm behavior, though the drop out rate was quite high (62.5%).

The STEPPS manual was translated into the Dutch language (10) and recently revised by two of the authors (BVW, IK), Paul de Bont, and Horusta Freije, and was introduced as *Vaardigheidstraining Emotie Regulatie Stoornis* ("Skills Training for Emotion Dysregulation Disorder"), or VERS. The STEPPS manual took about six months to translate. The manual has been updated, and made more culturally appropriate to suit the sober Dutch character.

The Dutch acronym, VERS, is similar to the English word verse (as in poetry). VERS also means fresh in Dutch, and because it was a new treatment, the term was felt to be appropriate for the program. In late 1998, STEPPS groups were started in Almelo, Deventer, and four locations in Groningen. Since then, groups in these locations have been started up every 6 months, for a total of four groups a year. Initially any patient with borderline features was allowed in the groups, but this practice was later stopped because it was observed that people with borderline features (but not BPD) were more likely to drop out. Patients are allowed to repeat VERS, and are encouraged to continue in individual psychotherapy.

There are several reasons for its rapid acceptance and dissemination throughout Holland. First, because Holland is a small country by U.S. standards (about half the size of Maine), and the number of therapists small, dissemination of knowledge through the mental health community is relatively rapid. Therapists are often acquainted with colleagues around the country. Second, though DBT was developed in the 1980s, and had become widespread by the mid-1990s in the U.S., DBT was introduced in Holland at about the same time as STEPPS, so had no time advantage. Both STEPPS and DBT were accepted by Dutch mental health professionals. The 20-week STEPPS program length was seen as advantageous over the one year DBT program. Because of the unpredictable North Atlantic weather patterns, and changing work schedules, a shorter program was felt to work better for both patients and therapists. The initial financial cost of DBT was greater as well, and this may have been seen as a disadvantage.

Compared with STEPPS, DBT was felt to be more labor intensive because it required both group and individual therapists trained in the DBT model; the need to assign patients to individual DBT-trained therapists; and the requirement to organize weekly groups for the DBT therapists. Despite their merit, these elements were thought impractical by many Dutch mental health professionals. Our Dutch colleagues were also concerned with the requirement that individual DBT therapists be assigned to borderline patients, which might lead to separating patients from their therapists so as to be assigned to a DBT-trained therapist. Because STEPPS is a "value-added" treatment, and supplements what the patient is already receiving, it does not separate the patient from his or her treatment team, and so these relationships are preserved.

Interest in VERS spread gradually, as it took time to make Dutch therapists aware of the treatment and its underlying concepts. Reframing BPD as a disorder of emotion dysregulation helped to modify the way BPD patients are treated in Holland. Borderline patients are hospitalized less frequently than in the past, and the stays are relatively short. They rarely require placement on locked units, and involuntary hospitalization is uncommon. As in the U.S., borderline patients are mainly treated in outpatient settings, or are enrolled in day treatment programs. Nowadays, at sites where VERS is offered, BPD patients are routinely encouraged to enter the program during the initial period of their treatment.

The Dutch patients have been enthusiastic about VERS. Some have expressed the opinion that VERS is the first helpful treatment they have received. One patient shared with her therapist (BVW) that VERS training helped her because she learned that she could do things for herself, rather than rely on therapists. The main problem in getting VERS established in the mental health system was that therapists were unaware of the new treatment, or were not interested in it. Patients reported that while spouses and family members were learning the "language" of VERS, many therapists remained unfamiliar with the approach. As more therapists have learned about VERS, this has become less problematic.

DATA SUPPORTING STEPPS

There are now two pilot studies in the literature supportive of STEPPS; one from the U.S., the other from The Netherlands.

Table 1 Results of Two Open Pilot Studies of STEPPS (or VERS) in Subjects with BPD

Author	Year	Location	# Subjects	% Female	Mean Age, Years	Results
Blum et al.	2002	Iowa	52	94	33	↓ BDI, ↓ BEST, ↓ PANAS-NA Scale
Freije et al.	2002	The Netherlands	85	91	32	↓ SCL-90 Subscales (D, A, IP) and General Symptom Index, and ↓ BEST

BDI = Beck Depression Inventory; BEST = Borderline Estimate of Severity over Time; PANAS = Positive and Negative Affectivity Scale; NA = Negative Affectivity; SCL-90 = Symptom Checklist-90; D = Depression; A = Anxiety; IP = Interpersonal Sensitivity.

The results of both are remarkably consistent, though the first study was retrospective and the other prospective (Table 1).

The study of Blum and coworkers (7) was a retrospective chart study which involved analyzing the experience of 52 patients (49 women, 3 men) who had participated in STEPPS groups between 1995 and 1998. The subjects were a mean age of 33 (SD = 9) years at the time of study entry (range, 18 to 51 years). All were engaged in individual psychotherapy, and all were prescribed medication, mainly antidepressants, mood stabilizers, or antipsychotics. Using a repeated measures design, patients experienced a significant decrease in symptoms associated with BPD as measured by their BEST total score. The largest effect was in the decrease of negative behaviors, noteworthy because these behaviors are ones that could lead to hospital care (e.g., self-harm, substance abuse, destruction of property, physical fights). Of 29 patients with data at week 10, 41% were considered responders (defined as a ≥25% decrease in their BEST total score). Beck Depression Inventory scores dropped significantly from 30 at intake, to 20 by week 13, a 34% drop. Improvement was also observed with the negative affect scores of the Positive and Negative Affectivity Scale (10).

In the study by Freije et al. (12), 85 patients (77 women, 8 men) enrolled in VERS groups in Groningen were assessed before and after treatment. The subjects had a mean age of 32 (SD = 8) years. They were assessed with the Symptom Checklist-90 (SCL-90) (12), a scale used to rate important mental health symptoms, and a Dutch version of the BEST (11).

In general, VERS attendees found it a valuable experience, and benefited from the lessons. Typical statements were: "I understand my emotional fluctuations better." "I can talk and think about my BPD without drowning in it." Homework assignments were completed about 80% of the time. Significant improvement was seen on all SCL-90 subscales, particularly those rating anxiety, depression, and interpersonal sensitivity, as well as the General Symptom Index; BEST scores were also significantly improved. The drop out rate was 34%, and Freije and coworkers (12) noted that while this was a cause for concern, at one site the rate was only 20%. This site had smaller groups (6 versus 10 subjects), and therapists made special efforts to develop cognitive schemas to help subjects to resist dropping out.

Overall, both the U.S. and Dutch studies were consistent in showing that patients and therapists reported high levels of acceptance for the treatment, and that patients improved in important target symptoms relevant to BPD. The next step is to test whether the improvements found in the two uncontrolled pilot studies will hold up in a more rigorous study design.

Randomized Clinical Trials

Randomized clinical trials are now underway both at Iowa and in Holland to compare STEPPS (or VERS) to treatment as usual (TAU). The format of both trials is similar. In each trial, study subjects are required to meet DSM-IV criteria for BPD, are at least 18 years old, do not have a psychotic disorder, and are not mentally retarded. In the Dutch study, subjects will be assessed using the Dutch version of the Structured Clinical Interview for DSM-IV personality disorders (14), and rated using a variety of instruments including the BPD Severity Index (15), the SCL-90, and measures of health care utilization. They will be rated at frequent intervals from the time of study entry, where it is anticipated that they will be followed from 2 to 26 weeks prior to randomization to the 5 month program or to TAU; follow up will continue for the balance of the 18 months.

At Iowa, the randomized controlled trial has the goal of recruiting a total of 160 subjects. Ratings are made monthly during the 20-week treatment phase and at 3-month intervals during a 1-year follow up. Subjects are initially assessed with the Structured Clinical Interview for DSM-IV (SCID) (16), the Structured Interview for DSM-IV Personality Disorders (SIDP-IV) (17), and are rated using a variety of instruments including the BEST, the BDI, the PANAS, and the Zanarini Rating Scale for BPD (18). Other measures include ratings of social and interpersonal function, adjunctive medication usage, deliberate self-harm, and health care utilization (e.g., hospital days).

STAIRWAYS AND OTHER NEW DEVELOPMENTS

There are several new initiatives being made in Holland relevant to STEPPS. STAIRWAYS, a less intensive "step-down" program developed to follow STEPPS is being introduced, and the Dutch translation is now complete. This program will soon start up in Groningen and Almelo, and will be referred to as "VERS 2." Psychoeducational family groups based on

STEPPS methods and the emotion dysregulation concept have been started. These are not only for family members of patients receiving treatment, but also families in which a relative has BPD and desires treatment, or is treated at another institution. An innovative group focusing on the mother-child relationship for patients with BPD and their children has been started as well. This group will deal with the specific problems borderline patients have with the parenting of their child.

In the U.S., STEPPS has been adopted to suit many different settings including partial hospital programs, day treatment, residential facilities, and substance abuse treatment. Programs for adolescents have been started, and one for mentally challenged persons. Several prisons have expressed interest in the program, and it is currently being used at correctional facilities in California, Iowa, Minnesota, and Nevada.

OTHER LOCATIONS FOR STEPPS

STEPPS programs have been started around Iowa, and in California, Nevada, Ohio, New York, and in Argentina and Belgium. The VERS manual has been translated into Norwegian, and groups will soon be started in Norway by one of the authors (WH). She is now working on the Norwegian translation of STAIRWAYS.

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