PBSP, DBT, MR, BPD: LETTERS WHICH SPELL HOPE

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Persons with Mental Retardation experience mental illnesses with similar frequencies as people in the general population, including Borderline Personality Disorder. Regardless of cognitive ability, this disorder is difficult to treat. Individuals dually diagnosed with Borderline Personality Disorder and Mental Retardation present unique challenges for clinicians. Treatment modalities need to be adapted to accommodate for visual and verbal processing limitations, concrete thinking patterns, and deficits with working memory. At **Advanced Behavioral Health** in Brooklyn Park, Minnesota, an emerging therapy for treating individuals with Borderline Personality Disorder and Mental Retardation is developing with positive treatment outcomes. This approach is based upon two different theories: **Dialectical Behavior Therapy** and the **Pesso Boyden System Psychomotor** method. The purpose of this article is to introduce the therapeutic community to the development and history of this treatment approach called, the PILOT Program. Thirty clients have participated in the **PILOT Program**. The Intelligent Quotients of these 30 individuals range from a Full Scale IQ of 75 to 55.

I. INTRODUCTION

This article begins by providing brief reviews of Mental Retardation (MR), Borderline Personality Disorder (BPD), Dialectical Behavior Therapy (DBT), and the Pesso Boyden System Psychomotor (PBSP) method.

Following these brief reviews, the author discusses the PILOT Program: an emerging therapy for treating individuals dually diagnosed with BPD and MR. The author of this article has been developing the PILOT Program along with Susan Voss, M.A., L.P.C., her business partner at Advanced Behavioral Health (ABH). The section on the PILOT Program reviews the therapeutic process from referral and initial interview to the various aspects of the treatment program, which are currently developed and in use at ABH. This paper also includes material still under development at ABH.

The final two sections of this article include a discussion of treatment outcomes based on the clinical experiences at ABH and a discussion on the need for future research and development.

II. BRIEF REVIEW OF MENTAL RETARDATION

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM IV, p.46) identifies Mental Retardation as follows:

1. An IQ of 70 or less,
2. Serious deficits in adaptive behavioral functioning, and
3. Occurs before age 18.

Characteristics of people with MR or Developmental Disabilities (DD) include difficulties with working memory, difficulties with speech and communication, inadequate social skills, difficulty with emotion identification, difficulty with change, and dependency upon routine.

Individuals with MR are frequent victims of sexual/physical abuse, taunting at school and in the community, and financial exploitation. Their cognitive impairments make emotional expression difficult.

Common teaching techniques include frequent repetition, hand over hand, modeling, role-playing, and chaining techniques.

For persons with DD, the world of emotion can be a frightening and confusing one. New clients come to us with the belief that feelings are bad and uncontrollable. They experience serious consequences as a result of explosive displays of emotion. They are frequently moved from home to home because, *"No one can control me."* As they grew up, priorities were placed on learning communication and daily living skills with emotional education as a distant goal. With their limitations in cognitive processing and limitations with communication skills, emotional expression is frequently limited to behavioral displays. They have not made the connection between the "icky" sensation in their stomach and the feel of anxiety.

III. BRIEF REVIEW OF BORDERLINE PERSONALITY DISORDER

The Bio-Social theory of BPD was developed by Marsha Linehan (1993), which states that there are two primary factors within BPD:

1) Emotion Dysregulation (*biological factor*), and
2) Invalidating environment (*social factor*).

Individuals experiencing emotional dysregulation are oversensitive, over-reactive, and cannot modulate strong emotion. This is a biological impairment of their emotion regulation system. Individuals who have been reared in an invalidating environment may have experienced sexual/physical abuse, neglect, taunting etc. An invalidating environment is one where the child's needs are disqualified or become secondary to another's needs. This is the social aspect of the Bio-Social theory.

Persons who meet these two factors will typically conform to the diagnostic criteria for BPD as outlined in the DSM IV (DSM IV, p.654). The BPD criteria follow:

FIVE OR MORE OF THE FOLLOWING:

1. Frantic efforts to avoid real or imagined abandonment
2. Pattern of unstable and intense relationships
3. Marked and persistent unstable self-image
4. Impulsivity that is potentially self-damaging
5. Recurrent suicidal and/or self-mutilating behavior
6. Affective instability due to a marked reactivity or mood
7. Chronic feelings of emptiness
8. Inappropriate/intense anger or difficulty controlling anger
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

IV. BRIEF REVIEW OF DIALECTICAL BEHAVIOR THERAPY

DBT grew from Cognitive Behavior Therapy (CBT). Developed by Marsha Linehan, DBT addresses the complex psychological needs of individuals with BPD (1993). DBT assumes that the fundamental nature of reality is change. Additionally, the dialectic between individual parts and the whole is viewed as the interrelated characteristic of reality. The dialectical worldview describes reality as dynamic and not static.

> *From the dialectical perspective, however, conflict that is maintained is a dialectical failure. Instead of synthesis and transcendence, in the conflict typical of borderline individuals there is opposition between firmly rooted but contradictory positions, wishes, points of view, and so on. The resolution of conflict requires first the recognition of the polarities and then the ability to rise above them, so to speak, seeing the apparently paradoxical reality of both and*

neither. At the level of synthesis and integration that occurs when polarity is transcended, the seeming paradox resolves itself. (Linehan, 1993, p. 35-36)

The following polarities represent dichotomous and extreme thinking, behavior, and emotion; and impede the therapeutic process. Therefore, they become a special focus for therapy.

Self-acceptance in the present.	⟷	Need for change.
Getting what you need. *(Therapy)*	⟷	Losing what you need. *(Progress = Less therapy)*
Environment is the sole problem.	⟷	I am the sole problem.

Within DBT, there is a hierarchy of therapeutic goals. The initial goal is to reduce risky behavior, such as self-injury, suicidal threats and gestures, promiscuity, substance abuse, etc. The next goal is to reduce therapy interfering behavior. These would include skipping therapy, coming late to appointments, neglecting homework, and refusing to complete diary cards/chain analyses. The goals that follow include increasing various skills, such as: increased awareness, improved interpersonal functioning, increased ability to moderate/manage emotion, and enhanced ability to cope with distress. Lastly, addressing and healing wounds from the past are the final goals of the therapeutic process.

Basic components of DBT include the therapeutic contract, individual therapy, skills training groups, and phone coaching between appointments. The agreement between therapist and client is based on mutual respect and commitment to therapeutic goals. The primary goal in individual therapy is to address the motivational issues, particularly the motivation to live vs. the motivation to die and/or engage in borderline behaviors. Common elements of individual sessions include review of diary cards, chain analyses, and problem solving. Group therapy attends to teaching the following skills: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Phone coaching between appointments assist clients in applying the skills to problematic situations in their lives as needed.

Mindfulness skills begin by teaching about the three states of mind: rational mind *(thought without feeling),* emotional mind *(feeling without thought),* and wise mind *(using both thought and feeling)*. Mindfulness skills increase abilities to observe, describe, and participate in experiences. Mindfulness skills also teach us to be non-judgmental, improve attention, and personal effectiveness.

Interpersonal effectiveness skills help clients to attend to relationships, improve conflict resolution skills, balance priorities, and build self-respect.

Emotion regulation skills assist with emotion identification/understanding, reduce emotional vulnerability, and decrease emotional suffering.

Distress tolerance skills assist individuals to cultivate positive uses for distraction, improve self-soothing techniques, and assess pros and cons for potential behavior/choices.

V. BRIEF REVIEW OF PESSO BOYDEN SYSTEM PSYCHOMOTOR

Diane Boyden and Albert Pesso developed PBSP in 1961 from their backgrounds as modern dancers and choreographers. By noticing the process of how feelings are expressed physically, Al and Diane uncovered basic patterns of human development. "As developmental drives unfold, they are experienced as emotions/impulses to action, and can be satisfied by specific responses from specific (genetically pre-programmed) target figures." (Kaufman)

PBSP developed as a system of emotional re-education. This system uses the resources of the person's body and mind to complete the five life tasks necessary for personal well-being.

1. Satisfaction of basic developmental needs *(place, nurture, support, protection, limits)*
2. Integration of polarities *(to "own" the whole self)*
3. Development of the consciousness *(to know we are alive and why)*
4. Development of the PILOT *(to be in charge of one's own life)*
5. Development of personal uniqueness *(to become who we truly are)*

The goal of PBSP is to change one's psychological map. The first step is to discover the current psychological map within its historical roots. The second step is to devise creative ways for satisfying unmet developmental needs. Through the process of noticing energy in the body, physical sensations, and patterns of thought, developmental deficits reveal themselves. Thus, opportunities for growth, healing, and satisfaction are also uncovered. When we develop and strengthen our PILOT *(our self-organizing command center)*, we increase our self-awareness, self-understanding, self-acceptance, and open ourselves to opportunities for healing through the completion and satisfaction of basic needs. "The ideal relationship of the child with the parents is not a static but an active and changing one. The process of becoming an autonomous, competent human being with a sense of one's own identity and place in the world is a resultant of a complex interaction of energies, behaviors, relationships, attitudes, and genetic processes" (Pesso, Chapter 4).

Here is an example of how psychological maps are formed:

ENERGY	The child has a need for nurture and support
↓	
ACTION	The child raises arms in the presence of the parent.
↓	
INTERACTION	The parent picks up the child and embraces the child.
↓	
INTERNALIZATION	"I am loved, cared for, and safe."

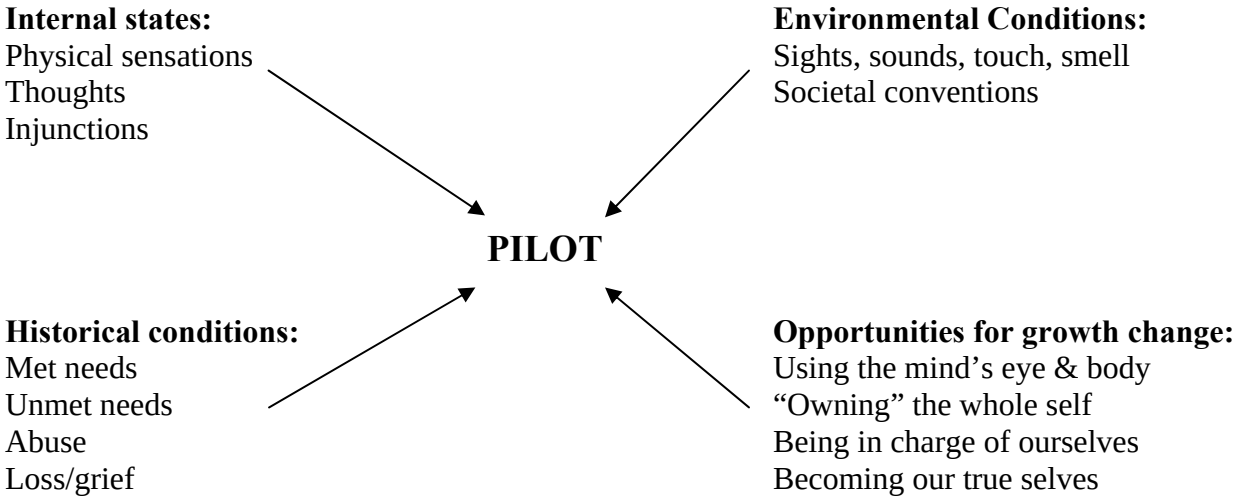
Here is an example of how unwanted detours or stop signs in our psychological maps may be formed:

ENERGY	The child has a need for nurture and support.
↓	
ACTION	The child raises arms in the presence of the parent.
↓	
INTERACTION	The parent turns away, yells, or hits.
↓	
SUBSTITUTE	Child may cry, pick up a teddy bear, or rock self.
↓	
INTERNALIZATION	"My needs are bad."

Those unwanted detours and stop signs manifest through maladaptive patterns of behavior, thought and relational ineffectiveness. In PBSP, the doorway to discovery and change is through the body: our physical movement, our physical sensations; and through the mind: our pattern of thinking and the wanted or unwanted injunctions that guide our lives. By using our mind's eye and our mind's body within the context of a highly structured and carefully composed intervention, a more appropriate substitute is posited. The individual is invited to imagine a symbolic representation of a parent who would have seen the child's need and responded to it. Further discussion of this intervention, called a "Structure" is beyond the scope of this article. However, those interested in learning more about structures may go to www.pbsp.com for more information.

Development of the PILOT is crucial to the task of psychological change. In order to develop, the PILOT needs information to perform its tasks of organizing and commanding one's life.

The PILOT receives information from our internal states, takes in information from outside ourselves, and incorporates information from our history. The PILOT can then organize this information and make choices about life.



VI. THE PILOT PROGRAM

DBT and PBSP make quite a jazzy combination. ABH utilizes the organizational principles of DBT along with its hierarchy for treatment goals. The use of diary cards, chain analyses, and combining individual therapy with skill building groups are tools from DBT.

From PBSP we utilize the concept of the PILOT and its teaching techniques and exercises. We also make use of symbolic therapy interventions within PBSP, specifically: the "Witness" figure and the symbolic projection of internal injunctions, called "Voices," which become the basis for changing one's psychological map.

The initial goal of therapy is to reduce risky behavior (DBT). The ultimate goal of therapy is to change the individual's psychological map (PBSP). Both goals require the therapeutic process to provide opportunities for one's PILOT to gain information about one's thoughts and feelings and one's urges and behavior. Both goals require the individual to be able to transcend oneself, to use one's mind's eye, and to think about one's thinking. Conventional wisdom teaches that persons with MR cannot perform these higher executive cognitive functions, such as thinking about one's thinking. At ABH we discovered by using concrete symbols and the educational exercises of PBSP, MR people can and do engage in meta-cognitive tasks. This is incredibly groundbreaking and a thoroughly exciting discovery.

A crucial component of the PILOT Program as developed by ABH is our encouragement of active staff involvement. Staff participation enables the therapist to gather thorough information about current problems and instruct them about possible interventions at home. Staff participation in groups will further instruct them. Clients experience staff as human beings who also need to utilize emotion regulation skills. Recently, a client stated, "Staff don't have problems with their feelings." Staff participation in the PILOT Program normalizes the process of coping with emotional ups and downs. It is common for staff to indicate to therapists and clients that they are using the tools they have learned in the PILOT Program to assist them in their everyday life.

A. Process of entering our program

1. Referral

A variety of sources refers individuals to our clinic: social workers, guardians, group homes, psychiatrists, or crisis homes. We complete a screening over the phone that includes questions related to the person's current behavioral/emotional difficulties, cognitive functioning, physical difficulties, current medications, and history of psychological services, as well as previous diagnoses. With this information, we can determine what method is best suited to serve the individual.

2. Initial Interview

Both PILOT Program therapists conduct the initial interview. Caregivers and guardians are also encouraged to participate in the initial interview. One therapist completes the diagnostic interview with the potential client, while the other

therapist completes a Vineland Adaptive Behavioral Scales (VABS) with the caregiver. During the diagnostic interview with the client, we assess the client's understanding/recognition of his or her current difficulties, their assessment of previous strategies, the current level of hope/hopelessness, and the ability to grasp abstract concepts. The VABS provides us with an assessment of the person's current adaptive behavioral functioning - communication, daily living skills, socialization and maladaptive behaviors.

At the conclusion of the initial interview, the two therapists briefly consult with each other to determine the appropriate therapeutic avenue. If the individual has met certain criteria for entering our PILOT Program a primary therapist is chosen based on the therapists' current caseload, client needs, and mutual schedules.

The PILOT Program entrance criteria:

- The client agrees that s/he needs to make changes.
- The client, residential staff, and guardian understand the level of commitment.
- The client's disability does not impair him/her from learning these concepts.
- The client's residential staff commit to assisting the client in learning and implementing the concepts.

3. Therapeutic Contract

When accepted into the PILOT Program, ABH establishes a therapeutic contract between the client and the caregivers. This contract outlines the expectations and level of commitment for the client, the therapist, and the caregivers.

Patient agrees to:

1. Attend all scheduled therapy sessions
2. Use safety management procedures to reduce harm to self and others
3. Appropriate use of the on-call phone
4. Stay in therapy session even when difficult
5. Attend Pilot Classes
6. Do daily and weekly homework

Therapist agrees to:

1. Treat the patient with respect
2. Be reliable and ethical
3. Find ways to help the patient feel life is worth living, while disclosing that the therapist does not have the control to keep the patient from harming themselves
4. Not give up

Residential staff agrees to:

1. Remind the client to bring therapy notebook to appointment
2. Assist the client with his/her worksheet
3. Assist the client with his/her therapeutic goals
4. Attend identified individual and group therapy sessions as scheduled
5. Agree to confidentiality requirements

B. Individual therapy before group placement

1. Awaken the PILOT

The initial goal of therapy is to awaken the person's "PILOT." The first stage to accomplish this is through identifying the physical location of the PILOT by pointing to the forehead. "The part of your brain that is located behind your forehead is what we call the PILOT. It is the big boss of you. It is the part that helps you make choices about what you do and how you behave. Just like a real pilot in a real airplane needs good information to get the plane to go where it needs to go, your PILOT needs good information about you so you don't crash. Your PILOT gets information from your 'feeling part' and information from your 'thinking part.'"

At this point, the therapist raises their arms to simulate the wings of an airplane. The right arm represents the feeling part and the left arm represents the thinking part. The therapist then raises their right arm over their head and says, "What happens to the plane if the feeling part takes over and the PILOT is not in charge?" "It crashes," is the common response. Then the therapist raises their left arm (the thinking part) over their head and says, "What happens if my thinking part takes over and I'm having a lot of bad thoughts?'" Again the common response is, "The plane crashes." So, "therapy is all about giving your PILOT good information, so you don't crash."

2. Early PILOT exercises:

The next step is, "Let's find your PILOT." Typically, our clients are unaware that they have a mind's eye. We will ask them to describe their bedroom. Usually when they describe their bedroom they point and gesture with their arms - indicators that their mind's eye is at work. "That's your PILOT working!" We will have them select an object. Then with their eyes closed, we have them describe it. "That's your PILOT working!" We will have them close their eyes and "see" themselves sitting in the office with their therapist. "That's your PILOT working!" On one occasion following a mind's eye exercise a client exclaimed, "Do you think my dad can do this?"

We also lead the client in a closed eye exercise where they "see" themselves walking out the office door, going through the waiting room, down the stairs, out the front door, experiencing the current weather conditions, opening the car door,

getting in, and driving off with their driver. “That’s your PILOT working! You can use your PILOT to help you plan events and practice events in your head.” Following this exercise, one young woman exclaimed to her therapist, “Dude! I do this all the time.” “Wow,” the therapist replied, “You already have a strong mind’s eye. That’s your PILOT working! Now your PILOT needs more information about your thoughts and feelings, and more experiences about how to handle the hard times.” She was proud to have had this success so early in therapy.

3. Goals of early therapy

An additional goal of this important stage of therapy is the reduction of risky behavior. Therapy is weekly. Every other week a staff attends the individual sessions to learn about the PILOT and to assist in problem solving related to relationships in the group home. Staff participation is crucial to success. They need to understand the concepts, language, and tools of the PILOT Program. Staff are crucial as they assist clients in globalizing learning to other areas of life.

In reducing risky behavior, we stress that regardless of your level of disability; hurting yourself or others is unacceptable behavior. The therapist explains to the patient, “You can want to do anything, but you don’t get to do everything.” This is the beginning of distinguishing between urges and actions. The PILOT recognizes the urges, notices the feelings attached to the urge and then decides how to act. In order to keep track of these urges - feelings - actions, we provide clients with individualized diary cards, which in turn provide the PILOT with valuable information. Urges and actions tracked on the diary card are selected according to the client’s current set of risky behaviors. The initial set of behaviors tracked is the most serious set of behaviors, such as, para-suicidal behavior, physical aggression, elopement, and unsafe sexual practices.

4. Diary Cards

Characteristically, our clients have some rudimentary reading and writing skills. Diary cards usually require the individual to mark a “yes” or a “no” to the various urges, feelings, and actions that are monitored on the cards. These diary cards are reviewed during therapy. For instance, a client may report having had the urge to cut oneself because they were angry, frustrated, and sad. However, the client did not follow through with the urge. “What did you do to help yourself instead of cutting yourself? This is important information for your PILOT. You can have the urge, but do something else.” The “something else” is usually in the form of a self-soothing activity. Self-soothing activities are listed and tracked on the second page of the diary card and are described as things we can do to help ourselves when we are having urges and BIG feelings. A BIG feeling is a feeling where the sensation of the feeling is experienced as extreme. Since a BIG feeling can be a terrifying experience for anyone, imagine how terrifying this experience can be for individuals with Mental Retardation and emotion dysregulation. Our clients often experience emotions as something omnipotent; something out of their control.

5. Ride the Wave

Riding the wave is a concept we developed to assist clients in understanding the anatomy of a BIG feeling. In our group room, we have a poster of a surfer riding an enormous wave. We also watch videos of surfers riding out various types of waves. The emotion or BIG feeling we experience is a wave that we need to ride out. The wonderful thing about waves and feelings is that if we ride it out and wait long enough the feeling or wave goes away. Eventually the wave reaches shore and disappears.

So, when we are experiencing BIG feelings, what can we do to help ourselves ride the wave, until it is gone? We typically encourage the client to practice a variety of self-soothing activities, designed specifically for the individual. They include relaxation tapes, music, blanket wraps, dancing, talking to staff, distracting oneself, or using PILOT exercises. The client is also encouraged to use our on-call phone, when having a difficult time staying in control. The phone is staffed from 9 AM to 9 PM. Individuals who use the phone understand that they will receive support in finding ways to remain in control. The phone counselor is trained in the PILOT Program. The phone rotates between the therapists and trained second semester graduate level students.

The initial goal in therapy is to reduce risky behavior, by strengthening the individual's PILOT and increasing the use of self-soothing activities. There is much repetition and practice of the coping tools designed specifically for each client. At this point in therapy, dealing with past trauma is limited. We want a person's PILOT adequately developed in order to handle the grief and rage that usually accompanies trauma.

6. Assessment and readiness for group placement

Finally, this stage of therapy includes assessment and instruction related to appropriate social skills that are necessary for group participation. Clients need to be able to listen, take turns, and delay gratification prior to group placement. They also need to understand and comply with principles of confidentially, mutual support, and appropriate interpersonal boundaries. We have two sections for the group experience, depending upon an individual's level of cognitive/functional impairment: a group for those who are mildly impaired, and a group for those who border between mild and moderate impairments. These two groups are on parallel tracks, learning the important skills in an environment compatible to their cognitive abilities. Additionally, for group placement, individuals cannot be actively psychotic or engaging in extreme self-injurious behaviors or physical aggression.

C. Individual therapy during group placement

Individual therapy during group placement supports and reinforces skills learned in the groups. Individuals with an IQ in the range of 65-55 will require frequent reinforcement

of these skills during the individual therapy sessions. Another focus of these sessions is with basic problem solving - managing conflicts in the group home and in the vocational setting. The presence of a staff person every other session adds to the clarity of current problems, and increases the likelihood of the completion of recommendations at home and at work.

Individual sessions without the staff present focus upon personal issues of the client - both historical and current. Here we will utilize the Witness figure (PBSP). The role of the Witness figure is to name and acknowledge the affect that the client is experiencing as they discuss various events. The Witness grounds the individual in the present as they remember past events. During this portion of the treatment process, the therapist and client seek to reveal learned injunctions called, "Voices." An example of a learned injunction might be, "Shut down when you feel angry." At ABH, we refer to these injunctions as the "*rules in your head*."

Following Linehan's hierarchy of therapy goals, the goal of healing past traumatic events takes place later in the therapeutic process. The client needs to have gained the necessary skills to manage the flood of emotions that typically accompany this kind of work. The client also needs to learn to trust one's own inner process. Building this kind of trust and learning these requisite skills takes time.

D. PILOT Classes – skill-building groups

The focus of these groups is educational and instructional, and we refer to our groups as "PILOT Classes." Therefore, clients and staff come to PILOT Classes prepared to learn. Although each group member is given an opportunity to "check-in," we endeavor to limit check-ins to general content. Content that becomes too personal is interrupted and re-directed to individual sessions. We strongly encourage staff to attend our PILOT Classes on a rotating basis. This gives the staff the opportunity to be learners along with their clients. The occasion of staff learning alongside clients facilitates the normalization of the practice of emotion regulation for clients. It is not uncommon for developmentally disabled individuals to believe, quite falsely, that disabled individuals are the only people who experience difficulty with emotion and behavior. We instruct staff how to talk about their PILOT and the emotional waves they undergo without revealing specific content. Therapists and clients in the classes do the same.

1. Feeling Part

In the "*PILOT Class: The Feeling Part"* we build upon the skills which were introduced in the early individual sessions. In the group setting, we do PILOT exercises together. Group members are afforded the opportunity to see others learn and grow. The PILOT exercises have been adapted from PBSP. These exercises were designed to elicit emotion, identify physical sensation, emotional movement, emotional sound, and satisfy curiosity. The exercises raise awareness of emotions and physical sensations which provide information to the PILOT and increase the individual's personal control. The PILOT exercises also make clear

that emotional experiences come from within the individual. The emotion that is elicited comes from within the self. It is not put upon the person by the therapist or other group members. This is a crucial insight. We want clients to understand and experience this reality so that they might begin to trust that healing will come from within, as well.

People with DD have limited instruction in emotion identification/expression which can cause serious behavioral disturbances. Therefore, gaining information about the world of emotion is a vital objective. As our clients learn about their feelings and the physical sensations associated with these feelings, the world of emotion is demystified. It becomes less frightening and less confusing. They see other DD and non-DD individuals needing to navigate the same world of emotion. For many, a new world of personal control and pride is now a possibility.

We also practice a variety of self-soothing activities together. Types of self-soothing activities range greatly from serene relaxation tapes and meditations to the use of "Flarp." Flarp is a putty-like substance that makes noises similar to flatulence. Laughter is a tremendous part of therapy. During some group sessions, our contagious and raucous laughter can be heard throughout the office building. Together we learn to use and trust a variety of self-soothing activities. Together we learn to ride the wave and learn the different levels of emotional waves. Together we learn how feelings are connected to thoughts and urges, and that neither condemnation nor praise is appropriate for the basic, human experience of feelings, thoughts, and urges. Praise is appropriate when we recognize and manage our emotional, cognitive and behavioral states in loving and healthy ways.

2. Thinking Part

In the "*PILOT Class: The Thinking Part,*" we continue to build upon skills learned in individual therapy and Feeling Part skills. There are actually two aspects to the skills learned in the Thinking Part groups: 1) Thoughts void of emotion—just the facts, and 2) Good/Bad thoughts—judgmental and non-judgmental thoughts that can intensify or reduce emotional responses.

An important skill in learning to regulate thoughts and emotions is to learn to speak facts without emotion. We call it the "Reporter." Group members are encouraged to report an event where they experienced some big emotions, but to tell it as if they were a reporter. Give us the facts alone. This way a person can explain an event without reliving the emotional waves.

An example of Good/Bad thinking (judgmental/non-judgmental) would be, "Beets suck," verses, "I don't like beets." Here we are teaching how to make a self-statement instead of a global judgment about a thing. Another example, "I never get to do what I want," verses, "Sometimes I get to do what I want." Here we are teaching to notice and avoid statements that use extreme language. We teach that a bad thought is a lie that makes feelings get bigger. The example

"Beets suck," is a lie because although the speaker may not like beets, there are many who do like beets. Likewise, beet lovers cannot say, "Beets are the best food on the face of the planet." This would clearly be a bad thought and a lie due to the fact it is a global statement based on an individual's preference. (The author of this article does not like beets and at times has fallen prey to the bad thought that beets really do suck)

A good deal of time is devoted to identifying bad thoughts and learning how to change them. We define Bad thoughts as extreme thoughts that are lies, which we believe and that make big feelings bigger. Words that tip us off that we are in the midst of a bad thought are the extreme words: always, never, no one, etc. It is surprising how often in casual conversation one will hear examples of such extreme statements. For individuals who are predisposed to problems with emotion regulation, extreme thoughts can create such huge waves of emotion that the person may feel that they are drowning in an emotional sea without a life preserver. This is the reason behind learning to "Ride the Wave" before tackling other more difficult skills. It takes a strong PILOT to recognize our responsibility in coping and managing our emotional states.

Group lessons and homework are designed to pick out the extreme words in a sentence, learn how to change the thought, and then to notice what happens to the level of emotion from a bad thought to a good thought. We begin by listening to others around us or on TV programs. We will watch an episode of a TV show and pause when we hear a bad thought. Recently we watched an episode of "I Love Lucy." Lucy alleged, "Ricky, you'll never let me be in your show!" What is the word that tells us this is a Bad thought? "Never," the clients answer. What is Lucy feeling as she says this? "Sad, angry, disappointed." How could Lucy change this to a good thought? "Ricky, maybe someday you will let me be in your show." How would Lucy feel if she said that? "Less sad and angry and maybe a little hopeful."

When individuals can identify bad thoughts in others and change them to good thoughts, then they can begin to identify and examine their own thoughts and increase their mastery of their own cognitive and emotional states.

Some of our clients may never be able to manage their Good/Bad thinking independently due to increased cognitive impairments and deficits with working memory. These individuals typically are in the mild-moderate level of mental retardation. They may continue to require cues and help from clinicians and staff to disbelieve the lies of the bad thoughts and to rephrase their thoughts to more truthful statements: "Bad things always happen to me," to "Sometimes hard things happen and I can handle it."

3. Interpersonal Effectiveness

Interpersonal effectiveness is the next skill set to teach and learn in the PILOT Classes. Currently ABH has only a few clients ready to learn these skills;

therefore, we have not yet developed these group sessions. However, the plan is to focus on teaching negotiating skills. We will pay attention to the tone and pitch of the voice, and to word choices. We will teach how to avoid power struggles. We will teach that no one is either all good or all bad. The clients, who are currently learning these skills, have demonstrated mastery at "Riding the Wave" and are able to change a "Bad thought" to a "Good thought" independently. They have learned to use the "Reporter voice" to turn off their feelings and have learned to trust their PILOT with information about their physical sensations, urges, feelings, and thoughts.

4. Maintenance

When individuals complete the skill-building groups – the Feeling Part, Thinking Part, and Interpersonal Effectiveness - we anticipate the need for a maintenance group. During the maintenance phase, clients would receive supportive care and reinforcement for previous learning. This phase would also assist clients to apply previously learned skills to novel situations.

VII. TREATMENT OUTCOMES

Thirty individuals have participated at some level in the PILOT Program at ABH:

- Eleven individuals are currently participating in both individual and group therapy.
- Eight individuals are currently receiving the individual portion of the treatment and awaiting group placement.
- One received individual treatment alone. Treatment was discontinued following successful completion of therapy goals.
- Three received individual treatment alone and transferred to different treatment programs.
- Three individuals withdrew from treatment as their personal choice.
- Two left treatment as results of a move.
- Two left treatment as a result of long-term hospitalization and had been in treatment three months or less.
- Nine individuals have shown remarkable progress as evidenced by zero to one psychiatric hospitalization, reductions in medication, improvement in vocational functioning, increased independent living skills, and have been in treatment for at least 18 months.
- Eleven individuals have shown moderate and intermittent progress as evidenced by zero psychiatric hospitalizations, longer intervals between episodes of self injurious behavior, longer intervals between episodes of verbal/physical aggression, increased ability to tolerate distress, and have been in treatment between six and eighteen months.
- Four individuals have shown mild to no progress and have been in treatment four or less months.

VIII. DISCUSSION FOR FUTURE RESEARCH

The immediate need for research and development with the PILOT Program is in the area of teaching interpersonal effectiveness skills to our special clientele. The use of role-plays and TV situation comedies may again prove to be instructive in this area.

The experience of working with these individuals at our clinic is exciting. The need for this type of treatment is immense. Currently, in the state of Minnesota, services to individuals with Developmental Disabilities are in jeopardy. A large community mental health facility recently closed. Psychologists and other clinicians shy away from treating these individuals due to the low reimbursement from Medicaid and Medicare. Crisis homes have limited availability. The significance of these current conditions for individuals with serious mental illness and behavioral disturbance is that these individuals may not receive appropriate treatment. Residential options for these individuals may become scarce resulting in commitment to a state hospital.

We need effective treatment options. At ABH, we are developing some instruments that will measure the effectiveness of our treatment program. We recognize the need for instruments to measure an individual's ability to identify emotion, to measure emotion regulation, and to evaluate behavioral functioning. These instruments would be administered at various intervals to clients (as self-reports) and care givers (as observer reports). We, at ABH, hope that with quantitative data demonstrating an effective treatment option, other clinicians may find this work interesting and fulfilling enough to pursue. It is also our hope that an effective treatment for dually diagnosed individuals could provide an additional option to state hospitalization.

Furthermore, it would be beneficial to research the application of this treatment model to other populations and develop adaptations to serve these populations. The anecdotes, shared by staff persons who participate in the PILOT Program with their clients, indicate that they have received vicarious benefits from their participation. We further speculate that with appropriate adaptations this approach could benefit adolescents who are experiencing emotional and behavioral disturbances.

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