# *The Muppet Show*'s Miss Piggy

## Introducing the Character

Miss Piggy is the porcine star of the long-running children's television entertainment and educational program *The Muppet Show.* Starting her illustrious career as a bit character on *The Muppet Show*, Miss Piggy, by virtue of her charisma, many musical and dramatic talents, and, of course, what became known as her powerful "karate chop," gained instant celebrity among children and adults around the globe. So popular was the porcine beauty that she often appeared outside *The Muppet Show* on television as well as in variety shows and movies with real-life stars, including the likes of Sylvester Stallone, Dolly Parton, and Herb Alpert of the Tijuana Brass. More recently, Miss Piggy and her perennial love interest, Kermit the Frog, appeared on *American Idol*. Her comedic, satiric, and dramatic talents have made her a recognizable and unforgettable mainstay of popular culture. Building on our impressions of Miss Piggy's character portrayal, the following basic case summary and diagnostic impressions describe concerns we imagine she has been experiencing at least since early adulthood, characterized by instability in interpersonal relationships, self-perceptions, affect, and impulsivity.

## Basic Case Summary

*Identifying Information.* Clarissa "Miss Piggy" Porciness is a 32-year-old Porcine American woman who resides in an urban center in Chicago. Miss Piggy currently is employed as the artistic director of Le Muppetrie Center for Artistic Studies in downtown Chicago. Currently she lives alone, following a divorce 3 years ago that ended her second marriage. She was dressed appropriately for the interview in a style that typically would be described as highly socially stylish and would be perceived as somewhat dramatic and seductive.

*Presenting Concern.* Clarissa Porciness set up an initial intake appointment at the Downtown Counseling Center at the urging of her assistant, Kermit Frogere, who reported that he was concerned about her changes in

mood at work and in her interpersonal relationships and her recent expressions of suicidal thoughts following the sudden ending of a romantic relationship. At times during the interview, Clarissa appeared to be experiencing low mood, was tearful, and expressed self-doubting thoughts, primarily when describing the rejection she felt at the ending of a recent romance and during two divorces. At other times during the interview, she appeared upbeat and confident and solicited the therapist's agreement that she was physically attractive and could likely attract "a new man any time I am ready."

*Background, Family, and Relevant History.* Clarissa Porciness was born the only child in a moderate income household in New Orleans, Louisiana. Clarissa's parents, Maurice and Claire Porciness, worked as street performers and on tourist stages in the city's French Quarter, and according to Clarissa's memory, they were "thrilled at having a daughter whom they hoped could carry on the family tradition," as she apparently demonstrated exceptional musical and singing talent at the age of 4. As a toddler and onward throughout childhood, Clarissa accompanied her parents to street festivals and clubs and was billed as the "Little French Marionette."

She attended magnet schools for the performing arts in the New Orleans school system. She reports that beginning in her later high school years, she began engaging in secretive romantic and, later, sexual relationships with same-age male peers at a neighboring school; secretive, brief relationships with same-age female peers at her own school; and, increasingly, short romantic relationships with college-aged men and, occasionally, women she encountered while working in tourist venues.

She was married briefly at age 19 while attending a local college for the performing arts. She described the marriage as conflictual. She married again at age 26, which she described as both "exciting" and conflictual. This marriage also ended in divorce. Clarissa reported that she and each partner were "still attracted to each other" but also each having sexual affairs with others, and that she eventually realized that she "felt unloved by my ex-husband, or anyone else." She has been successfully employed in her occupational field throughout adulthood.

*Problem and Counseling History.* Clarissa Porciness reports that she is ambivalent about the need for counseling but is open to beginning counseling "if it will help me learn to choose and keep the right man, or maybe woman, and feel more in control." She also agrees with her assistant, Kermit, that her mood ranges substantially from elation and extremely high self-confidence when "work and relationships are going great" on the one hand, to depression accompanied by self-demeaning thoughts and dramatic suicidal fantasies, usually in response to changes in romantic relationships, on the other hand. She also reports having some concerns about her use of alcohol in order "to feel better" and her difficulties managing angry outbursts when her creative work is underappreciated and her angry and rejected feelings when "my best friends and new boyfriends desert me."

Along with alcohol use, she reports "sometimes being a little worried" about impulsive shopping, especially for expensive high-fashion clothing and household items like new furniture and kitchen appliances, when she "isn't feeling so good about myself." She reports that "sometimes I am so angry and under so much pressure I feel like I'm dreaming, like I'm just watching myself go through the motions." She denies any current such thoughts or feelings. Overall, her problem history indicates a sometimes exhausting pattern of unreliable self-worth, relationship-seeking, and defending herself against extreme highs and lows in mood and adjustment via alcohol abuse, irresponsible shopping and spending, and reckless sexual relationships.

*Goals for Counseling and Course of Therapy to Date.* Miss Porciness is ambivalent about continued counseling and reported that she probably would rather see a medical doctor who could perhaps "give me something to calm my nerves" rather than a "head shrink who just wants to creep into my brain and dissect me like some sort of high school biology pig project." However, she voiced enjoying "having someone to listen to me" and agreed to return for at least several more meetings.

## Diagnostic Impressions

301.83 (F60.3) Borderline Personality Disorder.

Other factors: V61.03 (Z63.5) Disruption of family by history; V61.10 (Z63.0) Relationship distress with intimate partners.

## Discussion of Diagnostic Impressions

Miss Piggy made an appointment at the Downtown Counseling Center because, at the moment, she was experiencing depressed mood, suicidal thoughts, and feelings of rejection following the ending of a romantic relationship. In the interview, along with and in spite of her depressive mood symptoms, she emphasized her own attractiveness and ability to "attract a man." She also reported long-standing problems with dramatic fantasies about herself, use of alcohol to mitigate feelings of abandonment, instability (changes in affect lasting moments, hours, or days) and reactivity (angry outbursts, brief depressed episodes) of mood, impulsivity (in expensive shopping), highs and lows in self-worth, and on occasion, dissociative symptoms ("watching myself go through the motions").

The purpose of a *DSM-5* diagnosis is to describe a client's symptoms in order to communicate with other mental health professionals about the clinical picture the client is experiencing. A complete diagnosis presents all the various diagnosable disorders and other conditions that might be a focus of clinical attention. It also answers the questions "Does the client evidence any long-term pattern of maladaptive character traits that cause significant impairment or distress?" and "Does the client [present symptoms and experiences that] meet the criteria for any of the [diagnosable] personality disorders?" as well as whether mental retardation is present (LaBruzza & Mendez-Villarrubia, 1994, p. 86). Before moving on to a discussion of differential diagnosis for Miss Piggy, it is important for counselors to be aware that diagnostic labels and the expectations they create may communicate gender bias. This may be particularly so in the case of certain personality disorders that reinforce traditional stereotyped perception of men and women (Antisocial Personality Disorder for men and Dependent Personality Disorder for women) and anxiety and eating disorders, which are disproportionately assigned to women (Eriksen & Kress, 2008).

As we have portrayed her presenting concerns, we imagined Miss Piggy to have been experiencing an enduring, stable pattern of inner experience and behavior, present at least since early adulthood, characterized by problematic impulsive behaviors, together with instability in interpersonal relationships, self-perceptions, and affect, which are causing clinically significant distress as well as impairment in her work and personal

relationships. Her long-term functioning is characterized by problematic patterns present across her young adult and adult life span, which is the central feature of a personality disorder. Specifically, Miss Piggy's symptoms center on unstable relationships, reactive mood, unstable sense-of-self moving from idealizing to devaluing and impulsiveness, alcohol abuse, and problematic sexuality. These suggest a diagnosis of Borderline Personality Disorder.

Differential diagnoses might include one of the Mood Disorders; Substance-Related Disorders; as well as Delirium, Dementia, and Amnestic and Other Cognitive Disorders. However, her mood symptoms do not meet the full criteria for a diagnosable depressive disorder (such as Major Depressive Disorder or Dysthymia); there is not enough information to warrant an additional diagnosis of Alcohol Abuse beyond the criteria already provided for Borderline Personality Disorder; and her occasional dissociative symptoms are transient and in reaction to relationship stresses, which also are a part of the Borderline Personality Disorder diagnosis.

To round out the diagnosis, Miss Piggy's relationship stressors are emphasized in the "Other factors" section. The information gathered here is consistent with a diagnosis of Borderline Personality Disorder.

## Case Conceptualization

When Miss Piggy came into the Downtown Counseling Center for her first meeting, her counselor collected as much information as possible about the problems that led to her appointment. The counselor first used this information to develop diagnostic impressions. Miss Piggy's concerns were described by Borderline Personality Disorder. Next, the counselor developed a case conceptualization. Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person's experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Miss Piggy's Borderline Personality Disorder and the factors maintaining the concern. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a "road map" that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Miss Piggy better manage her emotions, relationships, impulses, and self-perceptions.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics to his or her understanding of the client. In this case, Miss Piggy's counselor based her conceptualization on Dialectical Behavior Therapy, a purist theory that is an extension of Cognitive Behavior Therapy. The counselor selected this approach based on her knowledge of current outcome research with clients experiencing Borderline Personality Disorder and other personality problems (Critchfield & Smith-Benjamin, 2006; Feigenbaum, 2007; Livesley, 2007; Looper & Kirmayer, 2002). According to the research, Dialectical Behavior Therapy is one treatment approach indicated when assisting clients with borderline personality symptoms (Feigenbaum, 2007). The approach also is consistent with this counselor's professional therapeutic viewpoint and the services offered at the Downtown Counseling Center.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients' needs (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure that follows.

Miss Piggy's Inverted Pyramid Case Conceptualization Summary: Dialectical Behavior Therapy

**1. IDENTIFY AND LIST CLIENT CONCERNS**

Unstable mood, angry outbursts
Occasional dissociation
Mood changes at work ("watching myself go through the motions")
Mood changes in personal relationships
Periods of elation and grandiosity
Periods of depression and self-demeaning
Moves from idealizing to devaluing self and others
Occasional suicidal ideation
History of being objectified by parents
History of being showcased child actress
"Little French Marionette" as toddler
Adult history of 2 divorces
Adult history of romantic rejections
Overvaluing of sexuality
Overvaluing own sexual attractiveness
Adolescent sexuality with older partners
Ambiguous sexual relationships with female partners
Dramatic, grandiose fantasies about self
Use of alcohol to mitigate abandoned feelings
Use of expensive shopping to mitigate devalued feelings

**2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS**

1. Emotional instability with highs and lows in mood and self-evaluation
2. Romantic relationship instability with overvaluing and devaluing
3. Impulsive and reckless behaviors and self-mitigating behaviors
4. History of objectification by parents

**3. THEORETICAL INFERENCES: ATTACH THEMATIC GROUPINGS TO INFERRED AREAS OF DIFFICULTY**

<u>Deficits in Regulation of Emotions and Behaviors</u>

1. Emotional inhibition in attempt to be accepted
2. Emotional overexpressiveness in attempt to have feelings understood
3. Separates self from ongoing events and interactions
4. Does not see reality without distortions
5. Does not accept experiences without attempting to hang on to or get rid of them

**4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES**

<u>Deeper Etiological Inference</u>

Invalidating Environment: Parental environment did not validate sensitive emotional core

*Step 1: Problem Identification.* The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor "casts a wide net" in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure below, the counselor included an extensive list of Miss Piggy's mood symptoms (mood volatility, elation vs. depression, angry reactions, etc.), romantic relationship dynamics (divorce, rejection, excessive sexual features, etc.), use of fantasies and impulses to self-regulate (including shopping and alcohol), occasional dissociation, and aspects of her developmental history (objectifying parents, etc.) at Step 1. She attempted to go beyond just listing the main reason for referral and to be as complete as she could.

*Step 2: Thematic Groupings.* The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Miss Piggy's counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into "areas of dysfunction according to important life situations, life themes, or life roles and skills" (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together (a) Miss Piggy's unstable mood, mood changes, and mood reactivity into the theme "Emotional instability with highs and lows in mood and self-evaluation"; (b) her romantic relationship issues into the theme "Romantic relationship instability with overvaluing and devaluing"; (c) her fantasies, expensive shopping, alcohol use, and dissociation into the theme "Impulsive and reckless behaviors and self-mitigating behaviors"; and (d) her problematic family emotional dynamics into the theme "History of

objectification by parents." Her conceptual work at Step 2 gave the counselor a way to begin understanding and explaining Miss Piggy's many concerns as a narrower list of a few clear, meaningful areas of negative functioning.

So far, at Steps 1 and 2, the counselor has used her clinical assessment skills and her clinical judgment to begin meaningfully understanding Miss Piggy's needs. Now, at Steps 3 and 4, she applies the theoretical approach she has selected. She begins making theoretical inferences to interpret and explain the processes or roots underlying Miss Piggy's concerns as they are seen in Steps 1 and 2.

*Step 3: Theoretical Inferences.* At Step 3, concepts from the counselor's selected theory, Dialectical Behavior Therapy, are applied to explain the experiences causing, and the mechanisms maintaining, Miss Piggy's intrapersonal and interpersonal difficulties. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying causes or psychological etiology of Miss Piggy's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

According to Dialectical Behavior Therapy (Linehan, 1993a; Morgan, 2005), a blend of behavioral and psychodynamic factors lead to clients' difficulties. These factors primarily center on the environment in which a child develops. Specifically, the theory suggests that when a child has a strong need for validation of his or her highly sensitive emotional core, but the child's parental or family environment does not provide adequate validation (i.e., the child grows up in an "invalidating and/or abusive environment"), then he or she may develop specific problems with the expression of emotions, engaging in experiences as they are and engaging in relationships from a rational perspective (Linehan, 1993a, 1993b).

As can be seen in the figure, when the counselor applied these Dialectical Behavior Therapy concepts, she explained at Step 3 that the various issues noted in Step 1 (unstable mood, etc.), which can be understood to be themes of (a) emotional instability, (b) romantic relationship instability, (c) impulsive and self-mitigating behaviors, and (d) parental objectification (Step 2), are understood to be a group of five problems with Regulation of Emotions and Behaviors drawn from the theory: (1) emotional inhibition, (2) emotional

overexpressiveness, (3) separation of self from events, (4) seeing reality with distortions, and (5) not accepting experiences without hanging on to or getting rid of them. These are detailed more fully in the figure below.

*Step 4: Narrowed Inferences.* At Step 4, the clinician's selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, "still-deeper, more encompassing, or more central, causal themes" are formed (Neukrug & Schwitzer, 2006, p. 207). Continuing to apply Dialectical Behavior Therapy concepts at Step 4, Miss Piggy's counselor presented a single, deepest, most-fundamental etiological inference that she believed to be most explanatory and causal regarding Miss Piggy's reasons for referral: experience of an invalidating environment in which her parents did not meet psychosocial development needs by validating her emotional core. When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2; the groupings then are explained using theory at Step 3; and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

The completed pyramid now is used to plan treatment, through which the counselor and Miss Piggy will address her deficits in regulation of emotions and behaviors stemming, more deeply, from her experience of an invalidating environment.

## Treatment Planning

At this point, Miss Piggy's clinician at the Downtown Counseling Center has collected all available information about the problems that have been of concern to her and Mr. Frogere. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Miss Piggy's difficulties and their etiology that we called the *case conceptualization.* This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan,* the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map "for reducing or

eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Miss Piggy, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include: (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to the client's goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured based upon a number of factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Beck Depression Inventory (Beck, Steer, & Brown, 1996), pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Miss Piggy, followed by her specific treatment plan.

*Step 1: Behavioral Definition of Problems.* The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Miss Piggy, there are two primary areas of concern. The first, "deficits in regulation of

emotions and behaviors," refers to her unstable mood, quick shifting from idealizing to devaluing herself and others, occasional impulsive and reckless behavior, suicidal ideation, and the use of alcohol. The second, "romantic relationship instability," refers to her quick shifting from idealizing to devaluing others and overvaluing sexuality and promiscuous and seductive behaviors. These symptoms and personality patterns are consistent with the diagnosis of Borderline Personality Disorder (APA, 2000a; Linehan, Heard, & Armstrong, 1993; Paris, 2000).

*Step 2: Identify and Articulate Goals for Change.* The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client's problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Miss Piggy, the goals are divided into two prominent clusters. Her "deficits in regulation of emotions and behaviors" requires that we enhance her ability to accurately label and express feelings, achieve balance between idealizing and devaluing herself, understand and eliminate dangerous and impulsive behavior, and reduce the frequency of her suicidal ideation and behavior. Her romantic relationship instability requires that we assist her to identify relationship triggers that lead to overvaluing and devaluing of others, to recognize and control her use of sex to manipulate others, to become comfortable with her own sexuality, and to decrease dependence on others to meet her own needs while building confidence and assertiveness.

*Step 3: Describe Therapeutic Interventions.* This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client's problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and

psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate "absolute efficacy," that is, the fact that counseling and psychotherapy work, and those that demonstrate "relative efficacy," that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy) and when delivered through specific treatment modalities (individual, group, and family counseling). In the case of Miss Piggy, we have decided to use Dialectical Behavior Therapy because of its demonstrated effectiveness with clients experiencing Borderline Personality Disorder (Binks et al., 2009; Feigenbaum, 2007; Linehan, 1993a, 1993b; Linehan et al., 1993). This therapeutic approach relies on a combination of methods (cognitive behavior modification, mindfulness training, transference work and dialectics) that target the common factors of personality disorder treatment (therapeutic structure, relationships) (Livesley, 2007) and the deficits that are specific to borderline conditions. Specific techniques for Miss Piggy will include strengthening of the client-therapist relationship, development of self-esteem enhancement techniques, exploring family-of-origin relationships, and group counseling to enhance relationship skills.

*Step 4: Provide Outcome Measures of Change.* This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Miss Piggy's case, we have included a number of these, including decreased client-reported frequency of impulsive and suicidal acts, clinician observation of stabilized mood, gradual increase in her GAF, and decrease of drinking in response to stress.

The completed treatment plan is now developed through which the counselor and Miss Piggy will begin their shared work to modify and hopefully decrease her prominent symptomatology, build coping skills, improve the quality of her relationships, and move in the direction of overall positive change. Miss Piggy's treatment plan follows and is summarized in the table that follows.

**TREATMENT PLAN**

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**Client:** Clarissa "Miss Piggy" Porciness

**Service Provider:** Downtown Counseling Center—Female Individual Counselor

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BEHAVIORAL DEFINITION OF PROBLEMS:

1. Deficits in regulation of emotions and behaviors—Unstable mood; rapid changes from sadness to elation, shifts quickly from idealizing to devaluing self, occasional impulsive and reckless behavior, suicidal ideation, use of alcohol and shopping to mitigate devalued feelings
2. Romantic relationship instability—Shifts quickly from idealizing to devaluing others, overvaluing of sexuality, promiscuous and seductive behavior

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GOALS FOR CHANGE:

1. Deficits in regulation of emotions and behaviors

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- Enhance ability to accurately label and express feelings
- Achieve balance between idealizing and devaluing self
- Understand and eliminate dangerous and impulsive behavior
- Reduce frequency of suicidal ideation and behavior

2. Romantic relationship instability

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- Identify relationship triggers that lead to overvaluing and devaluing of other
- Recognize and control the use of sex to manipulate others
- Become comfortable with own sexuality
- Decrease dependence on others to meet own needs; build confidence and assertiveness

THERAPEUTIC INTERVENTIONS:

An intermediate- to long-term course of individual counseling (6 months to a year) using key elements of Dialectical Behavior Therapy (DBT), supplemented by group intervention to address alcohol abuse and relationship issues

1. Deficits in regulation of emotions and behaviors
    - Encourage discussion of emotions, both positive and negative
    - Develop cognitive and behavioral strategies for enhancing self-esteem
    - Identify experiences that lead to positive self-regard and cognitions that interfere with it
    - Recognize relationship between internal states and the need to shop and drink
    - Identify emotional and behavioral triggers for impulsive behavior
    - Recognize the rewards and negative consequences for impulsive behavior
    - Develop a strategy for seeking help when feeling suicidal
    - Refer for evaluation to determine the need for medication
    - Refer to psychoeducational group for alcohol abuse
2. Romantic relationship instability
    - Discuss importance of working collaboratively with therapist around needs for dependency and boundaries
    - Explore family of origin relationship, particularly the devaluing and objectification by parents
    - Identify triggers for feelings of abandonment and their relationship to suicidal feelings and impulsive behaviors
    - Assign client to group counseling to build relationship effectiveness skills, including assertiveness and the expression of needs
    - Develop cognitive and behavioral skills to identify and correct distorted perceptions in relationship to valuation of self and others

OUTCOME MEASURES OF CHANGE:

The development of enhanced ability to regulate mood, self-esteem, and relationship stability will be measured by:

- Client's regular attendance in counseling and positive assessment of her ability to clearly communicate her thoughts and feelings
- Increased scores on standardized self-esteem inventory as well as client's self-report and clinician's recording of positive self-statements
- Decreased client-reported frequency of impulsive acts and suicidal thoughts
- Gradual decrease of stress-related and emotionally motivated drinking
- Client report of reduced interpersonal conflicts and improved communication and problem-solving within romantic relationships
- Clinician observation of client's stabilized mood along with pre-post measures of improvement on Beck Depression Inventory-II

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Miss Piggy's Treatment Plan Summary: Dialectical Behavior Therapy

| *Goals for Change* | *Therapeutic Interventions* | *Outcome Measures of Change* |
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| **Deficits in regulation of emotions and behaviors**<br><br>Enhance ability to accurately label and express feelings<br><br>Achieve balance between idealizing and devaluing self<br><br>Understand and eliminate dangerous and impulsive behavior<br><br>Reduce frequency of suicidal ideation and behavior<br><br>**Romantic relationship instability**<br><br>Identify relationship triggers that lead to overvaluing and devaluing of others<br><br>Recognize and control the use of sex to manipulate others<br><br>Become comfortable with own sexuality<br><br>Decrease dependence on others to meet own needs, build confidence and assertiveness | **Deficits in regulation of emotions and behaviors**<br><br>Encourage discussion of emotions, both positive and negative<br><br>Develop cognitive and behavioral strategies for enhancing self-esteem<br><br>Identify experiences that lead to positive self-regard and cognitions that interfere with it<br><br>Recognize relationship between internal states and the need to shop and drink<br><br>Identify emotional and behavioral triggers for impulsive behavior<br><br>Recognize the rewards and negative consequences for impulsive behavior<br><br>Develop a strategy for seeking help when feeling suicidal<br><br>Refer for evaluation to determine the need for medication<br><br>Refer to psychoeducational group for alcohol abuse<br><br>**Romantic relationship instability**<br><br>Discuss importance of working collaboratively with therapist around needs for dependency and boundaries<br><br>Explore family of origin relationships, particularly the devaluing and objectification by parents<br><br>Identify triggers for feelings of abandonment and their relationship to suicidal feelings and impulsive behaviors<br><br>Assign client to group counseling to build relationship effectiveness skills, including assertiveness and the expression of needs<br><br>Develop cognitive and behavioral skills to identify and correct distorted perceptions in relationship to valuation of self and others | **The development of enhanced ability to regulate mood, self-esteem, and relationship stability will be measured by:**<br><br>Client's regular attendance in counseling and positive assessment of her ability to clearly communicate her thoughts and feelings<br><br>Increased scores on standardized self-esteem inventory as well as client's self-report and clinician's recording of positive self-statements<br><br>Decreased client-reported frequency of impulsive acts and suicidal thoughts<br><br>Gradual decrease of stress-related and emotionally motivated drinking<br><br>Client report of reduced interpersonal conflicts and improved communication and problem-solving within romantic relationships<br><br>Clinician observation of client's stabilized mood along with pre-post measures of improvement on the Beck Depression Inventory-II |

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