COGNITIVE BEHAVIORAL CASE CONFERENCE

The Case of Howard

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This paper presents the case of Howard, a 51-year-old self-referred Vietnam veteran who was seeking a posttraumatic stress disorder (PTSD) compensation evaluation and treatment recommendations at his local VA hospital. At the time of the assessment, Howard was divorced, had not worked regularly for 7 years, and was living in the suburbs with his 9-year-old son. The evaluation revealed the presence of multiple Axis I disorders, including PTSD, major depression, obsessive-compulsive disorder, and somatization disorder. His primary concerns at initial presentation were intrusive memories of Vietnam, an inability to work, and ongoing health complaints. Further evaluation revealed additional concerns with paranoia, difficulties concentrating, and significant social isolation. This case study emphasizes Howard's psychosocial history, symptom presentation, and psychometric test results. Case summary and treatment recommendations are deferred until the final case conceptualization (Kimble, 2000).

HOWARD is a Vietnam veteran who was seen at a Veterans Administration (VA) hospital on five occasions for an evaluation that included a clinical interview, standardized interviews, a chart review, and psychological testing. Howard was self-referred to the VA for a compensation (disability) assessment for PTSD and was also seeking treatment recommendations. Given that a complete PTSD evaluation was the explicit and understood goal of the assessment, this case study emphasizes both the history and symptoms related to this diagnosis. Because of this explicit goal, there is a heavy emphasis in this case presentation on PTSD while underemphasizing the proper analysis of other significant comorbid conditions that became apparent during the course of the evaluation.

This is unfortunate. Howard's treatment is, to a large extent, interesting because of the presence of multiple disorders and the complexity that fact presents for treatment. Howard clearly meets criteria for four Axis I psychiatric disorders (PTSD, major depressive disorder, obsessive-compulsive disorder [OCD], and somatization disorder). While those clinical case participants (CCPs) asked to comment on PTSD may find their jobs somewhat easier, given the relative wealth of information, those CCPs asked to comment on other comorbid symptoms such as depression, obsessive-compulsive traits, and somatization may find their task somewhat more difficult.

This particular case conference is structured through solicitation of commentaries from experts in cognitive-behavioral therapy for three of the four Axis I disorders for which Howard carries a diagnosis. This structure reflects the intent of generating varied approaches to the case. The final response will synthesize these three papers into an integrated conceptualization and treatment plan.

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Identifying Information

Howard is a 51-year-old, divorced Vietnam veteran who lives in the suburbs of a northeastern city with his 9-year-old son. Despite not having worked for 7 years, he still lives in the small home he purchased 15 years ago with money he saved. His current income is primarily through a small Social Security disability benefit. Although his income is fixed and limited, Howard manages to stay within his budget. At present, his day is organized around taking care of his son, going to his medical appointments, and managing the household. Upon entering the clinic, his primary presenting complaints included intrusive memories and flashbacks of Vietnam, an inability to work, and frequently feeling sick. Although Howard did not initially complain of the following symptoms, ongoing evaluation also revealed difficulties with concentration, hypervigilance, paranoia, obsessive-compulsive traits, and significant social isolation. Despite his numerous concerns, Howard's primary goal for treatment was to "just help me forget about Vietnam."

Early History

Howard, the first of eight children, was born in 1946 in a New England seaside town. His father was a World War II veteran who worked as a guard at a local state prison. Howard's father was patriotic, moralistic, caring, and rigid. He probably suffered from the war but, if so, he never admitted it. Even though Howard's father never spoke against the war in Vietnam, he had expressed mixed feelings about his son enlisting. The only time Howard ever remembered his father crying was the day Howard received notice that he was going to Vietnam.

Howard's mother was consistently supportive and caring, in both his childhood and adulthood. Early in her married life, his mother primarily raised the children, but later she worked outside the home. Howard reported that he got along well with his siblings in his childhood, and perceived that all his siblings were well adjusted in their adulthood. Most of his siblings are married, have children, and have full-time jobs. Howard reported no history of psychiatric disturbances in any of his first-degree relatives. Howard's father remains in good health while his mother has survived both heart problems and breast cancer. Howard reported worrying frequently about his mother's health.

Howard said that he had a happy, if not idyllic, childhood. He lived close to the ocean, had many friends, and traveled with his family on the weekends. For the first 10 years of his education, Howard went to a local parochial school, but transferred to the local public high school when he started to have difficulty in languages. Despite these problems with languages, Howard was never held back, nor did he report ever failing a course. He had an intense interest in the arts, even as a young child, and enjoyed poetry, artwork, and classical music. During high school, Howard was socially and athletically active; he belonged to the literary club, the chess club, the boxing club, and the track team. He reported having a number of friends, and he dated as often as other boys his age. He enlisted in the Marine Corps Reserves during his senior year and started Basic Training shortly after graduation.

Military Years

Howard went to Basic Training and Advanced Infantry Training before leaving for Hawaii in the spring of 1966. He reported adjusting well to military life, and he enjoyed the discipline, structure, and camaraderie. Howard completed additional training in the Philippines and Japan before leaving for Vietnam in fall of 1966.

In Vietnam, Howard was first assigned to a Marine combat division in which he served in the infantry for 13 months and the military police for 4 months. While in Vietnam, he experienced a seemingly endless series of potentially traumatic, life-threatening events. He was involved in more than 50 firefights and contributed to a number of major campaigns. His involvement earned him a Combat Action Ribbon, the Presidential Unit Citation, and the Vietnam Service Medal with four stars. Howard was clearly a competent and loyal soldier who "not once fell asleep while on watch."

While on tour, Howard witnessed scenes that he could only describe as "grisly." He saw a number of men mortally wounded by landmines. He watched as two friends were blown 15 feet in the air by an explosion in a truck. On one occasion, in the pitch of night and pouring rain, he single-handedly pulled a legless man "off the wire" and back to safety. This endeavor took hours, and he had to comfort and quiet the man whose only thoughts were of water and cigarettes. Howard saw considerable carnage that involved mutilated American and Vietnamese soldiers. After one particularly brutal firefight, he remembers cleaning brain tissue off his lapel. Howard's most painful experiences in Vietnam involved witnessing atrocities carried out by American soldiers. It's unclear exactly what happened because Howard was simply too ashamed to discuss these incidents.

After one firefight that left many enemy soldiers dead on the battlefield, a sergeant tried to console the obviously shaken Howard by saying "Don't let it bother you, kid, it's just like hunting deer." At that point, Howard knew he was in trouble. He fought back the impulse to vomit, in part due to the sergeant's words, and in part due to the smell of decay rising from the battlefield. He made a commitment at that time "to pull myself together," feeling that if he did not, he would never make it to the end of his tour. Despite his attempts to keep himself firmly planted in reality, Howard began to experience symptoms while in Vietnam consistent with dissociation, visual hallucinations, and obsessive rituals.

When Howard transferred to the military police towards the end of his tour, his duty was much less dangerous. He returned to an American base after 13 months in Vietnam but returned to Vietnam as a military policeman to ensure that his brother would not be sent into a combat zone. This period was relatively uneventful, and Howard returned after approximately 4 months to the American base. Upon his return, Howard trained others to be motor vehicle operators and heavy truck drivers. He was transferred back to the Reserve in the summer of 1969 and was discharged 2 years later.

Civilian Life

When Howard finally returned from Vietnam, he lived briefly with his parents. It was at this time that he first noted he was having significant difficulty sleeping. He had rarely slept in Vietnam because he often had night watch, but he assumed that he would revert to his old sleep patterns upon his return. His problems sleeping were further complicated by the fact that he often woke up in a cold sweat dreaming of combat. During the day, he would have numerous intrusive memories and brief visual flashbacks of his experiences in Vietnam. Howard was highly anxious much of the time, had difficulty relaxing, and felt an increasing desire to simply be left alone. He found that work was helpful because it helped him focus and take his mind off his memories. Soon after his return from Vietnam, and with some of the money he had saved, he purchased the most remote

home he could find that still allowed him access to his job.

After his return from Vietnam, Howard put much of his energy into his career. At first, he worked sporadically and claimed to have turned down promotions in order to maintain a distance from others, but over time he became increasingly involved in his work and, eventually, the labor unions. While holding three successive union jobs in the 1970s and 1980s, Howard became active in union politics and eventually he was voted a union steward. Howard was intent on removing corruption from his union shops. He made the connection during his interview that his union work was directly related to his experience in Vietnam. If he could not make the "world safe for democracy" in Vietnam, then he sure as hell was going to weed corruption out of the American unions. As he put it, "I didn't fight over there in Vietnam so some maggot could steal from the old and the poor."

Needless to say, his actions displeased organized crime figures within the union. Their techniques for persuasion were convincing, even if they lacked subtlety. He was pushed down a flight of stairs, was involved in countless fights, and received numerous death threats. He was even offered a position within the organization. However, the mob's efforts only strengthened Howard's resolve. His work culminated in publishing a monthly union newspaper and testifying against the "mob" in a grand jury investigation.

Howard described that the pressure and stress were overwhelming at times. In 1976, Howard voluntarily went to a local hospital emergency room for a "nervous breakdown," although he described himself more anxious than depressed. In 1980, he began to see a private psychiatrist. He saw the psychiatrist for over a decade until the psychiatrist moved out of the area. The nature of the treatment was not entirely clear, but it did involve discussions of his war experiences and a medication regimen that included antidepressants, antianxiety agents, and Ritalin.

Howard continued to serve as a union official until he was "blackballed" from all union shops in the late 1980s due to his activism. After working for a few years in a non-union shop, Howard reports breaking out in hives one morning and literally collapsing on the job. He was taken to the hospital and has not returned to work since.

Howard married in 1983, had one child, and was divorced in 1989 after his wife asked for a separation. Howard's wife decided to leave the marriage because of a relationship she was having with another man. Howard's ex-wife showed little interest in child custody rights. Despite this, the divorce was followed by an extremely difficult custody battle between Howard and the Department of Social Services: they alleged that Howard was violent (due to his frequent altercations with organized crime), obsessive-compulsive, and suffering from his war experiences. After considerable time and effort, Howard won the custody dispute and obtained full custody of his son. It is likely that the combination of full-time work, the acrimonious custody battle, and single parenthood led to his collapse at work in 1991.

Symptom Profile, 1998

Howard's symptoms fall into four major categories. They will be listed in the order that Howard finds most distressing.

PTSD

Howard's first treatment goal was to "just help me forget about Vietnam." Although his PTSD may be the most distressing, it may not be the most disabling (see somatization and depression below). He reports intrusive memories that are prompted by the smell of starch, rain, and decay. The smells of decay that prompt his memories of battlefield carnage have generalized to include trash, sewage, dead animals, and rotting leaves. He believes he still has nightmares that are lost in the fog of medicated sleep. Many things that remind him of Vietnam upset him. His avoidance is significant. He only leaves the house when he must, and he goes shopping late at night to avoid the crowds. He does not allow his son to watch *Tom and Jerry* cartoons because he perceives them as too violent. Old hobbies no longer interest him, and he is unable to concentrate on books or movies. He has an overwhelming sense of a foreshortened future, prompting him to regularly update his will and keep his house clean of excess junk to ensure that, if he dies, his house is in order for his son.

Somatization Disorder

Howard began all five sessions with a report of his physical status (e.g., "I'm not feeling so well, Doc, my fever is back"). Interestingly, Howard made no conscious link between his psychological problems and his physical condition and resented the idea that there might be a relationship. His most common complaints were of "flu-like symptoms," which he attributed to a "chronic, recurring viral infection" of unknown origin. He stated that these symptoms became serious toward the end of his work history. After his collapse at work in 1991, Howard was able to return to work sporadically, but he often ended up leaving early or calling in sick. Eventually his employer asked him to leave due to the amount of work he was missing. His current symptoms include sporadic diarrhea, vomiting, fatigue, aches and pains, headache, loss of consciousness, and periodic skin problems. It's unclear the extent to which Howard's disability payments, stressful work history, and identity as a disabled veteran may

provide a "secondary gain" for these symptoms. On one occasion, despite feeling extremely ill and being bedridden, Howard responded immediately to his father's request for help when Howard's mother fell ill. For a week, Howard served as her primary caretaker. When asked about this quick recovery, Howard simply stated, "What could I do? She needed me." Also, it seems that his illnesses rarely interfered with taking care of his son, as he was able to make sure his son always attended school and extracurricular activities on schedule.

Depression (With Psychotic Features)

Despite self-described "30-second bursts of confidence," Howard's mood is chronically depressed. He reported that he was not really aware that he was depressed until after he stopped working, although, in retrospect, he feels that he may have been depressed at times earlier in his life. Today, Howard can no longer sustain interest in anything. His sleep is poor, his movements are slow, he has little, if any, energy, and he cannot concentrate. He feels worthless because he thinks he is no longer "a productive member of society" (a recurring theme), and he is extremely ashamed about his Vietnam experience and his altercations with organized crime. During the evaluation, it appeared that his physical symptoms and his mood were related: improved mood was associated with less physical symptoms and vice versa. However, it could not be determined whether his change in mood affected his symptoms, or whether periodic exacerbations in his physical symptoms decreased his mood.

His depression also seems to be associated with persistent paranoia and mood-related hallucinations that regularly affect his reality-testing and, sometimes, his behavior. Overall, he keeps his paranoia well-disguised, and it's likely that only treatment providers are aware of his paranoid ideation. He often refers to the world as "too small" and assumes that his history with organized crime will ultimately catch up with him. Thus, he often uses the "small world" schema as the basis for staying at home. He remains unsure about whether his phone lines might be tapped and, when pressed on this issue, he states that they probably are. In addition, his rare auditory and visual hallucinations clearly have paranoid themes. About 10 years ago, he reported hearing two voices talking on the telephone line, and one stating, "Shhhh, be quiet, he'll hear you." At one point, Howard had an extremely vivid visual hallucination (possibly during a hypnogogic state) that involved four apocalyptic horsemen. The four horsemen stopped long enough to debate whether they should take Howard along with them before disappearing through his window. Additionally, Howard's initial experience of a combat veteran treatment group he recently joined is interesting. He is convinced that the whole group is some type of "set-up" because he can not imagine that so many men have had experiences and feelings so similar to his own.

OCD

Howard reports that his obsessions and compulsions began in Vietnam when he was continually faced with unending filth and dangerous explosives. Today, he has obsessions about germs and fires, which he consciously relates to his military experiences. Howard never keeps more than half a tank of gas in his car "because you never know if it might explode." He checks electrical appliances (lights, toasters, televisions, stove, paper shredder, dryer door) numerous times during the day, and he always checks them when he wakes at night. He frequently checks his locks and looks out the window to see if his car has been broken into. Although there was little time for a careful behavioral analysis of these behaviors, it does not appear that he has to check things countless times once he has checked them. He washes his kitchen floor and vacuums his entire house more than once a day. If his son touches the floor while it is still wet, Howard will wash the floor again. He is extremely careful about the wastebasket and has developed hand-washing rituals around contact with trash. It also seems possible that the compulsions are maintained, not only by the reduction in anxiety they caused, but by the structure and meaning they bring to his day. When told that treatment for OCD symptoms often involves "rearranging and shuffling-up your schedule," Howard replied, in all sincerity, "That would be fine, Doctor, as long they give me enough time to plan for it."

Psychometric Test Results

Howard completed the Minnesota Multiphasic Personality Inventory-II (MMPI-II; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The validity scales of the MMPI suggest that Howard's concerns are consistent with individuals who are in considerable subjective distress and seeking assistance. Such a pattern is not uncommon in Vietnam veterans with PTSD. His K-corrected *t* scores were as follows:

Scale	Score	Scale	Score
1 (Hs)	101	6 (PA)	120
2 (D)	95	7 (PT)	94
3 (HY)	101	8 (SC)	117
4 (PD)	74	9 (MA)	56
5 (MF)	62	10 (SI)	69

The MMPI profile of 6–8 is consistent with an individual who may feel guilty about personal failures, has withdrawn from everyday activities, is suspicious, distrustful, avoids making deep emotional ties, and is most comfortable when alone. This configuration is also consistent with the presence of auditory hallucinations and para-

noid delusions. Howard is also quite elevated on the 3 and 1 scales, which is consistent with his numerous somatic concerns. Individuals with a 3–1 pattern typically are diagnosed with a somatoform disorder and often complain of headaches, chest pain, back pain, numbness, tremor, vomiting, nausea, weakness, and fatigue. In addition, Howard scored a 38 on the special PTSD subscale of the MMPI, exceeding the recommended diagnostic cutoff score of 27 for PTSD (Keane, Malloy, & Fairbank, 1984).

Howard's score on the Combat Exposure Scale is 29, which suggests that he was involved with "moderate to heavy" levels of combat while in Vietnam (Keane, Fairbank, Caddell, & Zimering, 1989). Howard's score on the Mississippi Scale for Combat-Related PTSD, a measure of combat-related PTSD severity (Keane, Caddell, & Taylor, 1988), was 122, which falls above the 107 cutoff suggested for Vietnam, combat-related PTSD. His score of 35 on the Beck Depression Inventory (BDI; Beck & Steer, 1987) indicates "extremely severe" levels of depression. His score of 32 on the Beck Anxiety Inventory (BAI; Beck & Steer, 1990) indicates "severe" levels of anxiety. Howard shows elevations on all scales of the Symptom Checklist (SCL-90-R; Derogatis, 1983) and exceeds scores typically seen in nonpsychiatric populations and psychiatric inpatients. Howard scored particularly high on the "somatization" and "obsessive-compulsive" scales, which are primarily elevated by frequent somatic complaints, obsessive thoughts, and repetitive behavioral acts.

Clinical Impressions and Diagnoses

Clinical impressions will be given in the summary conceptualization (Kimble, 2000). Howard's diagnoses based on the Structured Clinical Interview for the *DSM-IV* (First, Spitzer, Gibbon, & Williams, 1997) and the Clinician Administered PTSD Scale (Blake et al., 1990) are as follows:

Axis I
309.81, PTSD
303.3, OCD
300.81, somatization disorder
296.34, major depression, severe, with mood-congruent psychotic features

Axis II
799.9, deferred

Axis III
multiple complaints of unknown etiology

Axis IV
single parenthood, unemployed, financially limited

Axis V
GAF = 40

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Response Paper

Constructing a Model of Change: Clinical Commentary on a Complex Case

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In this clinical case commentary, attention was placed on the selection of the optimal targets and order of interventions for a 51-year-old male who meets criteria for four Axis I disorders: posttraumatic stress disorder (PTSD), major depression, somatization disorder, and obsessive-compulsive disorder (OCD). A theoretical model of what was learned in the context of trauma was developed to aid conceptualization of the interrelationship among the patient's symptoms. A model of change was presented, emphasizing cognitive-behavior therapy delivered in the context of a well-being therapy approach.

KIMBLE (2000) presents the case of a 51-year-old male who meets criteria for four Axis I disorders: posttraumatic stress disorder (PTSD), major depression, somatization disorder, and obsessive-compulsive disorder (OCD). With such a range of symptoms, attention has to be given to both the optimal targets and order of interventions, with the goal of selecting a treatment strategy that increases motivation for change while attending to the best targets for change. This is a difficult task, and, to achieve this goal, it is helpful to construct a theoretical model of what was learned by the patient. What are some of the core beliefs, strategies, and emotional styles that may help explain this patient's particular cluster of symptoms? Treatment interventions should then overlay these patterns with acceptable alternatives. In this clinical commentary, attention is placed on what was learned during the patient's Vietnam and post-Vietnam experiences.

Case Formulation: What Was Learned?

Lang's (1977) bioinformational theory of emotion as explicated by Foa, Steketee, and Rothbaum (1989) for trauma-related fear structures provides a useful heuristic for this discussion. The fear network for trauma-based memories is hypothesized to include (1) stimulus elements that represent the sensory cues (e.g., visual, auditory, and olfactory cues) associated with the trauma; (2) response elements that represent the cognitive, affective, physiologic, and behavioral responses to these cues; and (3) interpretive elements that include abstractions about the meaning of the event (e.g., "the world is not safe"). Once the network is formed, cues associated with this memory network (i.e., either stimulus, response, or meaning cues) are hypothesized to activate the full trauma network, thereby activating aversive emotions and urges to avoid or escape. For example, one of the stimulus cues for the patient, detailed well in the case example, is his sensitivity to the smell of decay, apparently a reminder of his more horrific experiences.

Despite a number of PTSD symptoms that were present when the patient first returned from Vietnam (e.g., flashbacks and avoidance of others), he was able to direct his attention toward work achievement. In fact, work may have served as a form of avoidance; while working, he was able to distract himself from memories of Vietnam. He excelled at his work over the next decade, but then was exposed to violence and threat of death secondary to his stand against corruption in his union. This threat may have had a role in aggravating aspects of his PTSD.

As detailed in the case report, the patient states that he did not "fight over there in Vietnam so some maggot could steal from the old and the poor." Despite his efforts against corruption, however, he is eventually excluded from his trade union. It is not difficult to imagine how these experiences of frustration and threat (occurring despite, and sometimes because of, efforts to do what is right) may have fused with his Vietnam-related memories: you try hard, persist, and fight (be a "good soldier"), but in the end you just suffer for your efforts.

In addition to intensifying maladaptive beliefs, his civilian experience with violence could have further shattered his tentative sense of safety. It is important to remember that associations in the trauma network are not fixed at the time of the trauma. For example, Kilpatrick (personal communication, cited in Foa et al., 1989) described the case of a rape victim who did not develop significant PTSD symptoms until months later, when she learned that her attacker had killed his next victim. Foa and colleagues interpreted this finding as the alteration of the trauma network to include a more pronounced representation of threat, thus altering the memory into a stronger fear structure. In Howard's case, civilian violence may have complemented his Vietnam experiences and intensified his feelings of being unsafe. Worse yet, this additional trauma occurred in a situation that was at the center of his coping efforts: work. This sort of punishment of his primary coping response certainly fits well with learned helplessness conceptualizations of depression (Maier & Seligman, 1976). It also corresponds well

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with conceptualizations of the learning histories of individuals with paranoid styles (Beck & Freeman, 1990).

Paranoia is an interesting symptom relative to the core features of PTSD. Foa and colleagues (1989, p. 171) aptly characterize the violations of safety brought by PTSD:

> In the absence of information about danger, most people assume that a situation is safe. For the PTSD individual, the lack of safety signals may be taken to mean that a situation is dangerous. Because it is virtually impossible to provide enough safety signals in any single situation to ensure no danger, the posttraumatic person is always on the alert.

Paranoia, likewise, is a worldview that assumes that, despite your efforts, things will go badly, perhaps because others are out to harm you. Certainly, Howard has had enough life experiences to encourage this perspective.

In short, Howard's withdrawal from his work world appears overdetermined: he has had ample experiences encouraging the belief that further efforts may well lead to further bad experiences. To his credit, his withdrawal from productivity appears to be role-specific. As detailed in the case example, Howard is effective in his roles as father and primary caretaker for his mother. Nonetheless, his withdrawal from the work world causes him emotional distress: he complains that he is "no longer a productive member of society" and suffers emotional pain because of it (perhaps further worsening his depression).

Howard's somatic symptoms are consistent with the range of nonspecific physical distress that can co-occur with PTSD and major depression. These symptoms might also have the secondary effect of providing him with a way to redefine his life role: I can't work because I am sick. Attention to somatic symptoms rather than emotional symptoms may also aid him in cognitive avoidance of PTSD cues. By not attending to his emotional experience, he may be able to minimize cues of the trauma (e.g., feelings of anxiety) and avoid the apparent need to analyze connections between emotions and external cues (e.g., PTSD-related stimuli).

Howard's OCD symptoms, including concerns about germs, fires, and explosions, also appear to be related to PTSD symptoms. These stimuli appear to be strongly related to his trauma network, with the patient himself linking the onset of obsessive concern about these stimuli to his Vietnam experiences of being exposed to "unending filth and dangerous explosives." Using the trauma-network heuristic, these cues are potential stimulus cues for the activation of the fear network, with resulting feelings of anxiety and dread, and urges to avoid these feelings. For years, Howard has used cleaning compulsions and checking behaviors as an avoidance/neutralization strategy. Although exposure and response prevention may be a useful tool to apply to these patterns at some point, it makes little sense to apply these procedures before first attending to PTSD associations that appear to motivate these obsessive and compulsive behaviors.

Putting Together an Intervention Strategy

All of these considerations provide the clinician with a number of working hypotheses for case formulation. PTSD is viewed as the primary disorder, and perhaps the central lynch-pin for addressing the other disorders. This conceptualization also fits generally with Howard's desires for treatment. His stated primary goal for treatment is to have treatment help him "forget about Vietnam," and he lists his problems in decreasing order of distress as PTSD, somatization disorder, depression, and OCD. The clinician's job of organizing a treatment approach for these areas of distress is simplified by the possibility that all of these symptoms may stem from the same set of core patterns initiated by PTSD.

Armed with this working hypothesis, the clinician could set to work with an informational, cognitive, and exposure-based treatment of the core features of PTSD. However, there is a central limitation to this approach: Howard is now only peripherally involved in role activities. It will be difficult to address issues of avoidance as long as motivation to return to avoided activities is lacking. This is best illustrated around job-role demands. According to the working hypotheses detailed above, Howard currently faces a struggle between his desires to be productive and fears and/or a sense of futility (learned helplessness) that may accompany any efforts to return to job functioning. Without a clear target on what he is going to gain, it will be difficult for him to complete the difficult task of applying exposure treatment. Rather than encouraging Howard to return to work or to work hard to push back PTSD symptoms, attention needs to be devoted to helping him maximize his well-being in life.

A Well-Being Approach

Well-being therapy (Fava, 1999) is a clinical approach that attends to the metaphorical "other side of the coin" from traditional cognitive-behavior therapy (CBT). Rather than attending to the reduction of symptoms, well-being therapy emphasizes the maximization of periods of well-being. Periods of well-being are monitored and discussed, and clinical interventions are designed to remove cognitive and behavioral habits and strategies that interfere with the attainment or maintenance of well-being. Of course, the clinical interventions for removing blocks to well-being may well be identical to the ones that would be applied under a traditional CBT approach, but they are couched under the broader um-

brella of improving quality of life. It is this stylistic approach that may be of direct benefit for Howard, because any treatment goals (e.g., reduce sensitivity to PTSD cues) would be targeted only as they arise from Howard's identification of these symptoms as blocking him from his quality of life.

This approach seems particularly important for Howard, given questions of secondary gain. Under conditions of potential secondary gain, singular attention to the removal of symptoms may be too threatening. Instead, primary attention is placed on helping Howard attain a better life; removing symptoms emerges as a goal only when these symptoms block well-being. The goal is to help Howard come to his own, specific motivations for elements of change (e.g., "because I want to enjoy the outdoors with my son, I don't want any smell of decay to mean 'Vietnam,'" or, "because I like the feeling of being productive and having part of my day structured, I want to consider a part time job"). Perhaps the most important aspect of this approach is not getting ahead of the patient, but keeping the patient in the lead with his statements of "I want . . ."

Elements of Treatment

Fairly quickly, according to the above model, a well-being treatment approach will lead to a focus on PTSD. To enhance motivation for change, effort should be devoted to enlisting Howard as co-therapist on the case. This means that a first step in PTSD treatment needs to be information, sharing elements of the model presented above. There is ample evidence that exposure-based treatment in conjunction with information and coping skills is associated with some of the highest effect sizes in the literature for treatment of PTSD (Otto, Penava, Pollock, & Smoller, 1996). However, with Howard, some care may need to be taken to preserve motivation during transition to exposure treatment.

For exposure-based treatment of PTSD, especially chronic PTSD where the patient has made some accommodation to having a chronic disorder, exposure-based treatment needs to be introduced in a way that does not drive the patient back to her or his chronic patterns of distraction and avoidance. This can be a particular challenge given the way that exposure to trauma cues is likely to induce avoided emotions that themselves can serve as trauma cues. We have described this experience as symptoms "folding back on themselves" in the context of the exposure session (Otto et al., 1996). That is, feelings of anxiety may be interpreted as threatening in their own right (e.g., "I am about to lose control," or "I'll go crazy if I keep this up"), but, more importantly, they may be experienced as additional cues of the original trauma (a time when the patient may have experienced autonomic arousal, dissociation, and/or fears of loss of control or death). This rush of additional, interoceptive cues of the trauma may lead the patient to feel that he can not tolerate the memories, and may increase the patient's sense that trauma-related memories are uncontrollable, unpredictable, and dangerous. Increased avoidance, potentially of the therapy session, may be the result.

To try to ward off these reactions, we have recommended use of interoceptive exposure to first treat catastrophic reactions to the symptoms themselves (Otto et al., 1996). That is, interoceptive exposure and cognitive restructuring procedures as commonly applied to panic disorder can be applied early in treatment to decrease fears of anxiety sensations and the likelihood that these sensations will serve as an independent cue of the trauma. These procedures, aimed at helping patients respond differentially to their emotions, may also help patients decrease avoidance of affect in general (i.e., blunting of affect). For Howard, with chronic PTSD and restricted activities and affect, an initial focus on restoring the safety of emotions may provide the best strategy for continuing a well-being approach and moving toward more in-depth CBT emphasizing exposure to traumatic memories and rehearsal of coping skills.

Concurrent with ongoing exposure-based treatment, attention will continue to be devoted to core cognitions associated with Howard's PTSD and civilian experiences. As hypothesized above, attention will need to be devoted to hopeless, helpless, and paranoid beliefs, relating the content of these beliefs to the trauma model presented above. Identification of more adaptive cognitive strategies would then proceed within the context of strategies to improve well-being. These strategies incorporate the cognitive-restructuring and activity assignments commonly applied to depression, and have been found to be useful for treating residual symptoms of affective disorders (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998). Treatment of the PTSD, depression, and role-dysfunction in the context of well-being therapy may also be sufficient to reduce the overfocus on somatic symptoms characterizing Howard's somatization disorder.

Additional strategies (exposure and response prevention) may need to be applied to OCD symptoms, but given the model above, this treatment should be conducted as a form of PTSD exposure (treating relevant obsessive-compulsive stimuli as trauma-related cues, discriminating present day from Vietnam cues, and then proceeding with response prevention).

Summary

In this clinical commentary, attention was placed on the construction of a theoretical model of the interrelationship between Howard's symptom dimensions and his

learning history. This model was then used to guide both the selection and the order and style of delivery of interventions. One goal was to plan for the way in which pathological patterns might constrain the acceptance of treatment. As therapy progresses, working hypotheses from this model should be tested (e.g., does Howard report core beliefs consistent with the model?) and updated, and, to the extent possible, both therapist and patient should share the same working model of change.

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Response Paper

Depression-Focused Treatment in the Context of PTSD and Other Comorbid Disorders

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This response paper describes cognitive-behavioral approaches to treating a patient, Howard, who is a combat veteran diagnosed with posttraumatic stress disorder, somatization disorder, major depressive disorder, and obsessive-compulsive disorder. This paper focuses on strategies for addressing the depression symptoms within the context of the broader clinical picture. Treatment strategies include increasing involvement in positive activities, self-monitoring of mood and behaviors, and cognitive restructuring. Collaboration with other providers is discussed. Potential problems are addressed, and expected treatment outcomes conclude the paper.

Presenting Problems

HOWARD specifically sought an evaluation for posttraumatic stress disorder (PTSD) to qualify for compensation and receive treatment recommendations. In addition to his primary concerns of intrusive war memories and flashbacks, he desired to "just forget about Vietnam." Howard also noted an inability to work and frequently feeling sick. Numerous other problems were elucidated during the course of the assessment.

Diagnosis

Multiple diagnoses are indicated by the included information. Howard's combat experiences, while not atypical, are clearly horrific and traumatic. Symptoms of PTSD, including sleep disturbance, combat dreams, intrusive memories, flashbacks, high anxiety, and withdrawal, occurred shortly after his return to civilian life in 1971. A sense of a foreshortened future is evident.

In addition to PTSD symptoms, Howard regularly reported physical symptoms, typically "flu-like symptoms," during the five sessions of evaluation. He also experiences a chronically depressed mood complicated by paranoia and mood-related hallucinations.

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learning history. This model was then used to guide both the selection and the order and style of delivery of interventions. One goal was to plan for the way in which pathological patterns might constrain the acceptance of treatment. As therapy progresses, working hypotheses from this model should be tested (e.g., does Howard report core beliefs consistent with the model?) and updated, and, to the extent possible, both therapist and patient should share the same working model of change.

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The information is consistent with the assigned diagnoses of PTSD, somatization disorder, major depressive disorder (with psychotic features), and obsessive-compulsive disorder (OCD). While the PTSD symptoms clearly appear to be most distressing to Howard, his chronic depression likely interferes significantly with his daily functioning and may impair his ability to benefit from treatment, unless the depression is specifically addressed. It is difficult, if not impossible, to consider treatment of these diagnoses separately, but this paper will focus primarily on treatment of the depression.

Assessment Plan

While Howard has already undergone an extensive assessment, some additional information would be valuable in planning treatment for his depression. First, it would be useful to understand the relationship of Howard's paranoia to his depression. Construction of a careful time line of onset of disorders might clarify the diagnostic relationships among symptoms. This information would be helpful to the clinician when attempting to help Howard discover his depressive thoughts and schemas and in devising interventions to challenge them. Paranoia that developed in the context of Howard's union experiences might have been more reality-based at the time, but not realistic now. However, if the paranoia was present even earlier, a different set of cognitive schemas may have developed that might never have had a basis in reality.

Self-report monitoring would also be quite helpful to not only assess the relationship of paranoia to his depression but also the relationship of his somatic complaints to his depression. Howard would be asked to monitor daily his mood, the intensity of his thoughts regarding the world being "too small," and the intensity of his belief that one day his history with the mob would catch up with him. Howard would also be asked to track his overall physical health and the number and severity of physical complaints each day.

Finally, Howard would be asked to record his daily activities. He would be asked to record what he does, whether he initiated the activity, and how much he enjoyed the activity. A baseline record of his daily activities and how he utilizes his time would help in quickly determining behavioral interventions to counteract his low mood. This assessment strategy would prepare him for regular self-monitoring during the course of treatment.

Case Conceptualization

Howard's depression is likely a result of multiple factors, including his combat and union experiences and his underlying vulnerability to depression. However, it is probably maintained by a negative cycle of particular thoughts (e.g., perceiving himself as a failure because he is not employed, believing he does not "measure up" to his father's ideal) and behaviors (e.g., social isolation) impacting his mood, which then impacts his thoughts and behaviors. Howard's depression (and other psychopathology) results in low mood and lack of motivation and initiative, which, in turn, lead to relative withdrawal from aspects of the world that do give him both a sense of pleasure and mastery. He also has certainly developed negative patterns of thinking (schemas) and is prone to cognitive distortions and errors (e.g., overgeneralizing negative events) that are common among individuals with depression, and these merely reinforce his low mood. All of this combines to create a perspective dominated by negative affect and poor self-efficacy and engagement with others. Much as the depression is maintained by this negative cycle, treatment will need to affect each aspect of this cycle to engender positive change. Recommendations will flow from the cognitive treatment model of depression initially described by Beck and colleagues (Beck, Rush, Shaw, & Emery, 1979) and further elaborated in many subsequent writings (e.g., Young, Beck, & Weinberger, 1993).

Treatment Plan

Treatment will involve components that address both Howard's behavior and his thinking. These treatment components will naturally need to be integrated with Howard's overall treatment and will be modified to reflect Howard's trauma history, somatization, and obsessive-compulsive thinking.

Howard will be initially presented with an explanatory model of depression that covers the relationship among mood, behavior, and thoughts. Following that, an overview of treatment describing the types of interventions and the necessity for Howard to be actively involved in all aspects of treatment will be presented. Presentation of the model and overview may serve multiple purposes: (1) engage Howard in the treatment process by presenting a rationale for the strategies that will be utilized throughout treatment; (2) appeal to Howard's capacity to function well (as evidenced by his history and present ability to care for his son) by demystifying treatment; and (3) facilitate Howard's investment in treatment by reducing the power differential between therapist and patient, especially since Howard has had a history of betrayal by those in authority, by presenting treatment as a collaborative process.

Specific treatment goals will be discussed and mutually determined. Given Howard's noted idealization of his father and his own proper role, he may have an unrealistic idea of what he is capable of achieving as a result of treatment. Cautiously establishing goals will not only

maintain an open and honest treatment atmosphere but will also provide some potential insight into the kinds of maladaptive and idealized cognitions that Howard measures himself against each day.

Building on the assessment self-monitoring, Howard will be asked to continue daily monitoring of his mood, physical complaints, and activities. Homework review will entail discovering what, if any, relationships exist among his mood, his somatic symptoms, and his behaviors. Howard will then be asked to identify activities that bring him pleasure, a sense of mastery, and control over his environment; and he will be assigned the task of engaging in a set of these activities each day. He will be asked to record his immediate experience of these activities, instead of generating retrospective accounts, as it is anticipated that his negative mood colors his perception of both the enjoyment and sense of accomplishment that he feels after certain activities.

If Howard is unable to spontaneously identify activities, therapy will help him generate a list of possible activities. These activities will build on the roles that Howard is already completing well, specifically fathering, and perhaps add some specific coping strategies for dealing with his anxiety. Some individuals with PTSD find various relaxation strategies helpful, while others will refuse to engage in them for fear that being relaxed will only allow more distressing memories to intrude. This possibility will be carefully assessed with Howard. If relaxation strategies are not feasible at this point, attention will be focused on behaviors such as exercising and perhaps returning to his earlier interest in the arts.

Once Howard is at least tracking his mood and behaviors and increasing his involvement in activities, he will be asked to begin tracking the thoughts associated with his mood. He will be asked to specifically monitor cognitions that occur when he observes a shift in mood and cognitions that occur while he is engaged in his assigned activities. This process will serve to illuminate the relationship of thoughts to behaviors and mood. Once Howard has learned to identify his cognitions, cognitive distortions will be identified and strategies for restructuring thoughts will be conveyed.

It is anticipated that some of the identified cognitions will be evidence of his paranoid thinking. Research suggests that cognitive restructuring strategies can also be applied to paranoia and delusions (Chadwick & Lowe, 1994; Walkup, 1995). Much as Howard will be asked to weigh the evidence for his depressive thoughts, he will also be asked to weigh the evidence both for and against his paranoid thoughts. Howard will be encouraged to view his thoughts as one of several possible interpretations of events, and he will be asked to consider and evaluate alternative views as well. As Howard continues to identify and restructure thoughts, it is anticipated that some core themes, or schema, will emerge. The assessment revealed areas to target for cognitive restructuring. Howard's image of a good father and his belief that he is not a "productive member of society" are areas to explore in discerning potential schemas that Howard uses to understand his own functioning. As schemas are identified, Howard will be called upon to consider how they might influence his approach to the world as treatment addresses his current problems in functioning. Problematic past functioning will serve as illustrations of how schemas have affected his behavior. These patterns will serve as sign posts for outcomes to avoid and will provide a forum for generating alternatives and testing hypotheses.

Three areas of strength emerged during the assessment, and the therapist will find it helpful to capitalize on these areas. The assessment suggests that Howard is caring well for his son and household, and even manages to "rise to the occasion" when called on by his family (such as caring for his mother when she was ill). Howard also was extraordinarily conscientious and dutiful in completing all necessary aspects of the assessment. Finally, Howard has a strong work history and moral compass, such as returning to Vietnam so his brother would not have combat duty and working against injustice in the union. Helping Howard to acknowledge his strengths may not only provide evidence for challenging distorted thinking but will allow Howard to reaffirm his personal abilities and values. These strengths are evidence to challenge Howard's faulty cognitions, and they also suggest possible behavioral practices that may help alleviate his low mood.

Treatment will continue to integrate both behavioral strategies and cognitive challenges within the context of Howard's daily functioning. The self-monitoring of mood, behaviors, and thoughts will provide information regarding Howard's psychological status. As Howard begins to note positive changes in his mood, and is able to apply the strategies to affect his psychological status and achieve his desired treatment goals, treatment will shift to relapse prevention. During this period, other problem areas will again be reevaluated and treatment recommendations will be made. Howard will also be asked to project realistically into his future to anticipate potential problems. The intention will be to practice problem solving and to apply these strategies in novel situations before treatment is discontinued.

Treatment for depression will begin to taper once Howard has mastered the behavioral and cognitive strategies and has gained an understanding of and begun to alter his core schemas.

Adjunctive Interventions

If it is possible to restructure and reduce Howard's paranoid thinking, he might benefit from group treat-

ment for PTSD. Many Vietnam-era combat veterans find a group atmosphere particularly supportive as they confront their traumatic past (e.g., Curran, 1994). If Howard continues to believe that other veterans could not have had such similar experiences as his own, then individual treatment specifically focused on helping Howard confront his traumatic history will be necessary.

It is anticipated that Howard already has other providers, specifically medical staff. Close collaboration with these individuals will be necessary, especially in light of his somatic complaints. They will likely welcome the support, as many health care providers become frustrated with patients who repeatedly have difficult-to-resolve physical complaints. Of greatest importance will be collaboration with his psychiatrist.

Preferably, his medication regimen will remain stable during the course of psychotherapy. In that fashion, Howard will attribute his gains to the work that he has done in psychotherapy as opposed to changes in his medication status. However, it may become necessary to change medications over the course of treatment, especially if Howard develops side effects or has symptoms (e.g., sleeplessness) that are not responding to psychotherapy but might respond to a medication.

Finally, it is extremely unlikely that treatment will progress in a linear fashion. While Howard was extraordinarily compliant with the assessment, and will most likely try quite hard in treatment, at any given time, his other, nondepression-related symptoms might be most distressing and interfering. Treatment flexibility, including adjusting strategies or making appropriate referrals, may be necessary. Close communication among all involved in Howard's care is essential.

Potential or Anticipated Problems

Howard will likely have difficulty as the treatment progresses from identifying pleasurable activities to addressing more internal stimuli, such as thoughts. The assessment information indicated that Howard is relatively closed to his affective experience. It may be very hard for Howard to identify his specific cognitions and schemas. The therapist should anticipate that this will be a difficult process and may require multiple attempts before Howard is able to identify his thoughts.

Additionally, the several other psychological problems that Howard experiences may at any time prove more problematic than his mood. The therapist will need to be flexible and open to changes in treatment plan to meet Howard's treatment needs. The therapist will likely need to incorporate a team of workers into Howard's care, especially if the therapist lacks expertise in one (or more) of Howard's problem areas.

Finally, the long-standing nature and complex interactions of Howard's multiple problems suggest that treatment may extend over a lengthy period. Providing an integrative treatment experience to address each of the problem domains necessitates many treatment sessions. Howard may find the treatment process quite difficult, especially given that he tends to be aware of his physical distress and less aware of his psychological distress. Howard may wish to stop treatment. Rather than potentially losing Howard from treatment, the therapist may need to consider the spacing of sessions or the possibility of allowing for brief breaks in treatment.

Expected Outcomes

Proven psychosocial interventions for each of Howard's presenting diagnoses exist, and the literature suggests reasonable outcomes for individuals with these disorders (Task Force on Dissemination of Psychological Procedures, 1995). One must enter treatment with that hopeful perspective, but the therapist will need to temper that perspective with reality. Howard's problems are long-standing and interwoven. Combat veterans can be notoriously difficult to engage and retain in treatment. The therapist will have to "work" to keep the treatment process moving and will need to communicate with other providers. This will not be an easy case. However, given Howard's level of premorbid functioning, seeming degree of family support (even though he does not avail himself of it), lack of reported violence and substance abuse, and clear psychosocial strengths (good parent, moral convictions, conscientiousness), Howard is as ready for treatment as he will ever be. It is expected that he will experience some improvement in functioning and a reduction in symptoms. However, it is doubtful that Howard will achieve his idealized outcomes (full-time employment, "forgetting about Vietnam"). Treatment outcome is only likely to be satisfactory if realistic goals are established at the outset and the entire team of providers and Howard are able to collaborate in his care.

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Response Paper

Treatment of Concurrent PTSD and OCD: A Commentary on the Case of Howard

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The complexity inherent in treating patients diagnosed with multiple disorders often leaves clinicians feeling unsure of how best to encourage change, or even where to begin. The present commentary discusses the interplay between the symptoms of posttraumatic stress disorder and obsessive-compulsive disorder (Kimble, 2000). Focusing on the need to assess the interplay of the two symptom clusters, the paper presents a model for understanding the etiological and functional relations that could link the symptoms of posttraumatic stress disorder and obsessive-compulsive disorder. Further, the paper discusses ways in which a clinician might approach such complex cases in order to address all of the client's needs in an effective and efficient manner.

Over the past 6 years, I have been involved in the evaluation and treatment of several individuals who carry comorbid diagnoses of posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD). Although these cases are not overwhelming in number, they represent some of the most difficult cases for conceptualization and treatment planning. The two disorders share a number of characteristics and functional relationships that complicate interventions. In order to address the needs of these clients, a therapist must carefully evaluate and conceptualize the interrelations of the observed symptoms. This is particularly important given the additional complexity of Howard's case reflected by the additional disorders, social limitations, and employment problems (Kimble, Riggs, & Keane, 1998). This conceptualization forms the guide for prescribing specific interventions to treat the identified problems.

One of the most frustrating aspects of the treatment of clients who present with these two disorders is that there are well-established cognitive-behavioral treatments for each of the disorders in isolation, but implementing these interventions is complicated when the disorders are interconnected. Exposure and response prevention as a treatment for OCD is one of the most powerful treatments available for an illness previously thought intractable (Riggs & Foa, 1993). Recent advances in the treatment of PTSD have found similar behaviorally based exposure techniques (Foa & Rothbaum, 1998) or cognitive restructuring (Resick & Schnicke, 1993) to be effective in reducing PTSD symptoms. Thus, it is tempting to address Howard's problems by implementing the treatment for one disorder (for example, OCD) and, once those symptoms are ameliorated, move on to address the symptoms of PTSD. In some cases, this may be the treatment approach that is used. However, prior to beginning such a course of treatment, it is imperative to determine if and how the symptoms of the two disorders are interconnected. For, as we will see, the functional interrelation of symptoms may make it quite difficult to successfully treat either disorder in isolation.

The case description offers little information regarding the details of Howard's OCD symptoms but gives some guidance as to the direction of future assessment and interventions. Howard's obsessions and compulsions appear to fall into two major content areas: concerns about dirt and germs, with the associated cleaning and washing rituals; fears of imminent danger (e.g., break-ins, fires, explosions) and the checking rituals that are related to these fears. There is also a sense of orderliness or structure conveyed in the idea that Howard would need "time to plan" for alterations in his schedule. Thus, we have some idea of how an intervention aimed at the OCD symptoms might proceed. Exposure exercises would likely focus on contact with dirt and germs as well as leaving windows unlocked and appliances on (or at least unchecked after use) as well as "unplanned" disruptions to Howard's orderly routine. Response prevention instructions would aim to eliminate washing, cleaning, checking, and ordering rituals in all of their guises. This having been said, there is much we do not know about the true function of the rituals and obsessions. Even in a case where OCD symptoms were the only presenting com-

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plaint, much more information is needed prior to initiating intervention.

In a case such as Howard's, where the OCD symptoms appear closely intertwined with symptoms of PTSD, additional assessment is imperative. The case description provides some information that will help guide the initial attempts to understand the connections (or lack of connections) between Howard's PTSD and OCD symptoms. Following these leads may provide some idea of where our interventions for each individual disorder will run into difficulties as well as potential strategies for overcoming these problems.

In Howard's case, understanding the potential link between his obsessive-compulsive symptoms and his posttraumatic symptoms begins with his understanding of their etiological connection. According to Howard, both disorders have their basis in his experiences while serving in Vietnam. His combat experiences are clearly sufficiently traumatic to result in PTSD, and there are substantial content-specific symptoms that strengthen the conclusion that these experiences led to his symptoms. Howard also indicates that his OCD symptoms began while he was stationed in Vietnam. Specifically, he relates some of his concerns regarding germs and dirt to the filthy conditions in which he served. Other fears (e.g., explosions, fires) are also linked in Howard's mind to the events of his military service.

It is certainly plausible that when faced with the filth of combat in the jungles of Vietnam, Howard became concerned enough about germs and dirt that he crossed the line into obsessions. Similarly, if faced with the potential of dangerous explosions on a daily basis, one might easily become overly concerned about such dangers and adopt an overly cautious way of living that would be diagnosable when the danger is removed. Additional aspects of Howard's combat experience may have contributed to the development of his OCD symptoms. In particular, Howard's descriptions of specific traumatic events seem to relate those events to his OCD symptoms. For example, Howard vividly described having brain tissue from a dead soldier cling to him after a battle (certainly enough to make me want to wash for an extended period). On a more subtle note, Howard describes feeling extremely upset by the deaths resulting from combat (even the deaths of the enemy). It is possible that this concern for others may be related to a heightened sense of responsibility for the safety of others, which is often seen in people with OCD and almost never seen among individuals with other anxiety disorders. It is not clear from the present description if such a sense of responsibility for others is present in this case, but it would seem important to assess to determine if it is.

If Howard's perception of the etiological connection between his PTSD and OCD symptoms is correct, he and his therapist may expect some difficulties in planning and implementing treatment for his symptoms. For example, behavioral treatment of dirt and germ obsessions and cleaning compulsions would typically involve physical contact with surfaces that the client perceives to be dirty or potentially infectious. During such treatments, the therapist works with the client to identify and focus attention on feared consequences of these behaviors in order to promote habituation of the client's fear. In Howard's case, though, I would expect that exposure to dirt and germs would elicit real memories of his trauma as well as feared consequences to the current action. This is not necessarily a hindrance to treatment. Indeed, exposure to concrete trauma cues may prove useful in behavioral treatments for PTSD (Roemer, Harrington, & Riggs, in press). However, the likelihood that exposure to such cues will lead Howard to experience both memories of past experiences and fears of future consequences to his actions makes such exposures more complicated. The therapist must attend carefully to the content of the client's fearful reactions to assure that these exposure exercises effectively address the intended symptoms.

In addition to the difficulties offered by the apparent etiological link between Howard's PTSD and OCD symptoms, treatment will be complicated by any functional links between the symptom clusters that exist in the present day. For example, it is possible that Howard's attention to dirt and other possible dangers (e.g., explosives, fire hazards) serves to exacerbate some of his PTSD symptoms by actually increasing the likelihood that his traumatic memories will arise. Similarly, Howard's compulsive cleaning and checking help him manage his PTSD symptoms as well as his obsessive fears. If this is the case, then the exposures and response prevention instructions (to touch dirt and refrain from compulsive cleaning) will, in the short term, exacerbate his PTSD symptoms. Indeed, in some cases, the compulsive ritual may function solely to reduce or control intrusive thoughts associated with PTSD (i.e., there may be no fear of the consequences of contamination). In such a case, exposure to feared stimuli would result in the occurrence of the feared consequence (i.e., the recollection of traumatic material). Habituation of the fear would not occur and, therefore, such treatment may be detrimental. In these cases, or in cases such as Howard's, where exposure is likely to elicit both obsessive fears and traumatic memories, it is important for the therapist and client to be aware of the goals of the exposure (i.e., what thoughts are being targeted) and to develop means to assure that the intervention is successful in this goal. Again, it is important to note that the use of cues to elicit traumatic memories is not necessarily problematic and likely will prove helpful in the long run, as long as this is the goal of the exercise.

Although my experience with cases similar to Howard's suggests that the most likely functional connections between OCD and PTSD symptoms are that obsessions exacerbate PTSD symptoms and compulsions serve to manage both obsessions and intrusive traumatic thoughts, other possibilities exist and should be evaluated. For example, it is possible that memories of past traumatic events serve to distract individuals from more frightening obsessions. In this way, traumatic memories might function similarly to cognitive compulsions, and response prevention instructions aimed at preventing traumatic thoughts should be implemented. This runs directly counter to the goals of exposure-based treatments for PTSD and should be approached with caution. It would seem likely that trauma-related thoughts and memories that serve to reduce fears associated with obsessions are qualitatively different from the traumatic memories typically seen in PTSD. I would expect that fear-reducing thoughts would appear qualitatively similar to the worries associated with generalized anxiety disorder. In the case of a veteran such as Howard, we might observe thoughts about the maltreatment of veterans or the politicization of the war in Vietnam rather than recollections of specific traumatic events. These intellectualized ruminations may serve to distract from more salient fears (either obsessions or specific trauma memories). Alternatively, obsessive worries may serve to distract a client from traumatic memories. Thus, it may be easier for Howard to worry about the dirt in his house than to systematically recollect the trauma of his combat experience. If this is the case, Howard's obsessions can be conceptualized as serving an avoidant function within his PTSD and should be addressed in the same way as other avoidant behaviors.

Finally, functional relationships may have developed that allow some behaviors classified as symptoms of OCD to compensate for problems arising from Howard's PTSD symptoms. For example, his tendency toward orderliness and structure in his life may serve to compensate for memory and concentration problems associated with PTSD. In this case, the therapist may need to work with Howard to find other (less compulsive) ways to compensate for these deficits. If these behaviors are not functionally related to Howard's obsessions (or if his concerns about forgetting have not become obsessive) it may be possible to leave these behaviors in place while treating his other compulsions. However, the therapist must assess this carefully as Howard's reaction to the suggested change in his routine suggests that his schedule is compulsive and aims to reduce distress that is probably obsessive.

Clearly the interconnection of PTSD and OCD symptoms in cases such as Howard's may significantly complicate their treatment. In particular, attempts to treat the symptoms of one disorder may significantly exacerbate the symptoms of the other. This is of particular concern in the case of PTSD because increased symptom levels are associated with a variety of potentially dangerous behaviors, including violent outbursts and suicidal gestures or attempts. Thus, it is imperative that when faced with such a case, therapists do not rush to begin an intervention aimed at one or the other disorder despite the data that suggest behavioral interventions are highly effective for the two disorders. A careful assessment of the interrelationships of the PTSD and OCD symptoms is necessary prior to starting the treatment of either disorder.

Although I have not conducted a systematic assessment of cases in which PTSD and OCD co-occur, in each of the eight to ten cases that I have evaluated or treated, there has appeared to be a functional relationship between the two clusters of symptoms. Understanding the functional interaction of PTSD and OCD symptoms is important because it offers a likely reason why the straightforward treatment programs that have been developed for each of the disorders in isolation will not work when treating the two disorders conjointly. Despite these complications, the proven efficacy of exposure-based treatments for these two conditions suggests that the implementation of such treatments will prove the most successful course of treatment for a client who has both disorders. The implementation of such interventions should be approached cautiously and be based upon a careful functional assessment of the individual's specific symptoms.

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Summary

Treating PTSD in the Presence of Multiple Comorbid Disorders: The Case of Howard

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This paper integrates the comments of Otto (2000), Bufka (2000), and Riggs (2000) on the case of Howard (Kimble, 2000), a 51-year-old Vietnam veteran who presented with multiple comorbid psychiatric concerns. This summary conceptualization outlines themes that were common among all three case commentaries and emphasizes issues related to comorbidity. Common themes include the importance of patient preparation for treatment, the necessity for initial and ongoing functional assessments, the value of utilizing patient strengths, the significance of acknowledging the interplay among symptoms, and the advantages of multidisciplinary treatment. All three case commentaries were cautiously optimistic that change could be implemented even in this complicated and chronic case.

In our experience, it is the presentation of numerous concurrent clinical concerns that typically makes a particular posttraumatic stress disorder (PTSD) treatment case complicated (Kimble, Riggs, & Keane, 1997). Unfortunately, the presentation of at least one comorbid psychiatric disturbance with PTSD may be more the norm than the exception (Keane & Kaloupek, 1997). Keane and Wolfe (1990) randomly selected 50 treatment-seeking outpatients with PTSD and found that they averaged 3.8 diagnoses, including PTSD. Kulka et al. (1988) used a large field survey in the National Vietnam Veterans Readjustment Study (NVVRS) to evaluate 3,016 Vietnam veterans, Vietnam-era controls, and civilian controls. In this sample, 98.9% of those veterans with PTSD met criteria for at least one other diagnosis. In the National Comorbidity Study, Kessler, Bromet, Hughes, and Nelson (1995) found that 88% of males and 79% of females with PTSD carried at least one additional diagnosis, and 59% of the men and 44% of the women met criteria for at least three additional diagnoses. Across these studies, diagnoses of substance abuse and depressive disorders were most frequent.

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Such figures call into question the value of any treatment for PTSD that does not take into consideration other concurrent psychiatric concerns. While experimentally validated treatments for PTSD clearly exist (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Keane, Fairbank, Caddell, Zimering, & Bender, 1985; Resick & Schnicke, 1992), the implementation of such treatments to traumatized individuals can be complicated. In cases such as Howard's, the presence of multiple problems may compromise, or even contraindicate, specific treatments for PTSD. In these cases, the patient's other problems must also be identified, prioritized, and successfully treated so that the client's concerns are comprehensively addressed.

Dealing with the many clinical issues presented by PTSD patients with concurrent diagnoses can be daunting for even the most experienced therapists. The lack of a single clear point of intervention may lead the provider to engage in a series of unsystematic attempts to deal with multiple problems simultaneously. Alternatively, clinicians may experience a therapeutic paralysis, an inability to intervene in any area out of concern for exacerbating another. Even in a very complicated case such as Howard's, certain themes about treatment arise across all three case commentaries. These themes reflect the fundamentals of sound cognitive-behavioral treatment for any combination of symptom presentations: the importance of the initial and ongoing assessment; the need for treatment prioritization and treatment preparation; and the value in emphasizing strengths, recognizing symptom interactions, and considering multidisciplinary treatment. The following summary conceptualization will highlight these similarities as they relate to Howard's presentation.

Case Conceptualization: Symptom Formation

Despite Howard's "idyllic" childhood, all of the clinical case participants (CCPs) recognize that some of Howard's current concerns have their origins in lessons learned during his early years. It is not that Howard's childhood was insidiously difficult or painful, but, over the years, there was a growing discrepancy between expectations built in childhood and the reality of Howard's life. Specifically, Howard feels that as a citizen and a father, he must be a good role model who is hard-working, independent, and "a productive member of society." Sadly, Howard is convinced that he is none of these.

What Howard does not realize is that his "failures" do not so much stem from inadequacies as they do his tendency to become involved with battles he can not win. Throughout his adult life, Howard has engaged in struggles and movements that were so large they would have swept any person aside in their wake. For example, he

started his adult life as a soldier in a war that, some argue, could not be won. He then spent many of his adult years fighting corruption in a city where graft is a perennial part of the political landscape. Most recently, he struggles alone against significant psychological concerns which he thought he could overcome if he just tried harder. Given that his expectations were to "win the war," "stop the corruption," and "beat this illness," Howard clearly positioned himself to fail.

In 1991, when Howard collapsed at the time clock, he had cornered himself with his own expectations and was faced with a difficult choice: either continue to fight and pay the associated price *or* give in to his feelings of inadequacy. For the most part, Howard chose to do the latter. Even today, he will only admit to himself that he became too physically ill to work. But there are two clear pieces of evidence that contradict this belief. First, Howard is never too ill to take care of his 9-year-old or his aging mother—taxing jobs by anyone's standards. Second, he feels tremendous guilt about being out of work, an emotional response that suggests he was not simply robbed of his capacity to work due to a physical disability.

Howard's early adult choices, first to join the marines and then to fight corruption, had one more significant consequence: they continually placed him directly in harm's way. In addition to these ongoing threats, by 1991 Howard had gone through a divorce, was isolated, and had just won a long and bitter custody battle for his only son. This perpetual stress was sure to have a significant impact on his psychological well-being. Exposure to chronic stress has been directly linked to the etiology of both PTSD and depression. It is also likely that such stress played a role in the exacerbation of his obsessive-compulsive disorder (OCD) and somatization.

Case Conceptualization: Symptom Maintenance

Howard's rigid ideals, his adult "failure" experiences, and his chronic exposure to stress clearly led to his collapse in 1991. However, his ensuing withdrawal and full-time fatherhood have not served to ameliorate his symptoms. Based on Howard's self-report, his PTSD, obsessive-compulsive, and depressive symptoms have all worsened in the past 7 years, while only his physical complaints have improved slightly.

Why did Howard, for the most part, get worse after leaving a stressful and dangerous lifestyle? Ostensibly, these changes in his symptoms are associated with his conversion from full-time worker to full-time father. Certainly, structure plays a role. At work, clear goals kept Howard focused; at home, Howard has no strict schedule. Distraction through work is a strategy used by many PTSD sufferers to minimize intrusive symptoms. Howard's stopping work, not surprisingly, led to an increase in these symptoms. His increased obsessions within the past 5 years may be related to a desire to structure his time at home and accomplish tasks he feels are worthwhile (e.g., clean the floors, check the appliances, vacuum the floors). While staying at home may serve to reduce overall anxiety associated with PTSD and OCD, it exacerbates Howard's depression by placing him further away from his goal of being "a productive member of society."

Given the mixed outcome resulting from Howard's avoidance, he is ambivalent about his desire to change. After 7 years, his current lifestyle has brought a stability to his life that was never present previously. It appears that his current lifestyle achieves two important, but unstated, goals: it provides his son with a sheltered upbringing, and it reduces *external* stressors. Howard may be willing to pay a high price to achieve these goals. Howard's reclusive behavior is further reinforced by the few costs that he could identify. Had it not been for the possibility of financial compensation for PTSD, it is likely that Howard would never have come to any clinician's attention.

Treatment Plan

But Howard did come to the VA for a compensation evaluation, and, in the process, expressed a sincere desire to change certain aspects of his life. He explicitly stated at the outset that he wants to "forget about Vietnam," return to work, and feel less sick. While the three CCPs were asked to comment on different aspects of the case (depression, obsessions, PTSD), certain common themes arose in all of the case conceptualizations. The following treatment conceptualization will emphasize these similarities.

Initial Assessment

All three CCPs concur that further assessment is necessary before initiating treatment. The nature of the compensation evaluation focused on accurate diagnoses, not the functional relationships associated with symptom development. Thus, the data have limited utility in developing a comprehensive treatment plan. A more thorough functional analysis would be necessary to understand what triggers Howard's flashbacks and memories, what symptoms keep him from working, and why Howard experiences an increase or decrease in somatic symptoms. Further assessment before beginning treatment would improve the provider's understanding of the interplay among the clusters of symptoms as well as crystallize initial treatment strategies. Bufka (2000) specifically suggests that the development of a symptom time-line would assist in the analysis of symptom onset and maintenance. While Bufka specifically states that a time-line would help in deciphering the etiology of Howard's paranoid symp-

toms, a time line would also allow a therapist to understand whether depressive symptoms preceded or followed the onset of PTSD symptoms. Obviously, such knowledge would affect subsequent treatment planning. For example, if depression is the result of a failure to cope with prior symptoms (PTSD, somatization), one would hypothesize that remediation of PTSD or somatizing symptoms might alleviate depression.

Prioritization of Goals

Initially, it may appear that the most difficult aspect of Howard's case is deciding how to proceed with treatment. It is rare when any client presents with only a single area for intervention, and Howard is certainly no exception. Riggs (2000), for example, acknowledges that treatments for cases with comorbid diagnoses "represent some of the more difficult cases with regard to conceptualization and treatment planning." There are validated and effective cognitive-behavioral treatments for PTSD (Keane, Fairbank, Caddell, & Zimering, 1989; Otto, Penava, Pollock, & Smoller, 1996), OCD (Foa & Riggs, 1993), and depression (Young, Beck, & Weinberger, 1993), but a cognitive-behavioral therapist is still left with the questions, "Where should I start?" and "How will these treatments interact?"

In Howard's case, he has the specific goals of "forgetting about Vietnam," getting back to work, and minimizing somatic symptoms. All CCPs agree that helping Howard with his first goal, "forgetting about Vietnam," is the best place to start. It is consistent with his own goals, and Howard is motivated to address this issue. Otto (2000) further suggests that Howard's PTSD symptoms may be a "central lynch-pin" for addressing the other disorders. He argues that "organizing a treatment approach for these areas of distress is simplified by the possibility that all of these symptoms may stem from the same set of core patterns initiated by PTSD." Given Howard's goals and the central role that PTSD symptoms are likely to play in Howard's overall psychological well-being, it seems that the most logical place to start is with the treatment of Vietnam-related memories.

Preparation for Treatment

Most cognitive-behavioral therapists would agree that treating trauma-related memories means utilizing some form of direct therapeutic exposure, and that utilizing direct therapeutic exposure requires some form of preparation. Both Bufka (2000) and Otto (2000) specifically discuss the need to prepare Howard for treatment. This is particularly important in Howard's case because the therapist is likely to utilize exposure-based techniques early in the treatment process. Bufka discusses the need to provide Howard with an overview of the treatment in order to engage him in the process and facilitate his investment in recovery. Bufka also feels treatment preparation is particularly important in Howard's case because of his inclination to idealize and the likelihood that he may set unrealistic goals for what he may be able to achieve in treatment (i.e., forgetting about Vietnam, returning to work soon). Helping Howard become involved with setting clear, realistic goals may also provide insight into any idealized cognitions that he has and fails to live up to.

Otto (2000) discusses the need for "interoceptive exposure" (Otto et al., 1996) in order to prepare Howard for the memories, the feelings, and the anxiety that exposure treatment for PTSD symptoms may generate—reactions that could possibly cue further symptoms and lead to increased avoidance. The goal of interoceptive exposure would be to help Howard react to his returning feelings and memories with less fear and anxiety. For further details on these procedures, see Otto et al.

Keane (1995) and Kimble et al. (1998) have specifically discussed the role of exposure therapy in the overall psychological treatment of PTSD. Both recommend exposure-based treatment only after the PTSD patient is emotionally and behaviorally stable, understands the typical effects of trauma and the common treatments, and has the resources to cope with the stress that exposure-based treatments may induce. Elsewhere, Litz, Blake, Gerardi, and Keane (1990) add that it is important to confirm that the patient has adequate motivation for intensive treatment and demonstrable psychophysiological reactivity to the memories of the trauma. Taking these concerns into consideration in Howard's case, a therapist would want to take some time early in treatment to educate him about PTSD, to discuss his treatment options, and further assess his available coping strategies. One might even advise a therapist to "test out" Howard's reactions to a detailed account of his trauma in order to assess if he is physiologically reactive to the memory, and to evaluate how he copes with any symptoms the intervention might produce.

Challenging Maladaptive Schemas and Avoidance

Otto (2000) suggests that Howard blames himself for "failure" experiences that, ultimately, have left him hopeless. He concludes that Howard "has had ample experiences encouraging the belief that further efforts may well lead to further bad experiences." Bufka (2000) picks up on this theme as she discusses the role that idealized schemas play in Howard's current depression. These schemas are rarely challenged, given the severity of Howard's avoidance. Further, all CCPs recognize that his avoidance plays a central role in the maintenance of Howard's current behaviors. While avoidance may serve to reduce general anxiety, it also inhibits recovery from obsessions, compulsions, and PTSD-related memories. The avoidance may also increase Howard's depression.

None of the CCPs indicate that there is a specific time in therapy when negative schemas and avoidance should be treated but, rather, indicate that such cognitions and behaviors should be challenged as they are identified during the course of therapy.

Emphasizing Strengths

All CCPs discuss the importance of emphasizing and building on Howard's strengths. Otto (2000) sees such an effort as part of what he calls the "well-being approach," which focuses on removing impediments to well-being rather than attending only to a reduction of symptoms. Otto argues that the well-being approach may be of particular value in Howard's case because possible secondary gain associated with his illness (i.e., compensation) could potentially hinder approaches attempting to remove symptoms. Bufka (2000) explicitly recognizes that Howard brings a number of strengths to therapy. He is conscientious, organized, moral, and has an admirable history as a soldier, an employee, and a father. Bufka sees Howard's strengths as important counter evidence that could be used to challenge distorted self-schemas that he might have about his own personal abilities.

Symptom Interactions/Ongoing Assessment

All three CCPs recognize that treatment of any one set of symptoms is likely to effect the quantity and quality of the other symptoms. Otto (2000), for example, acknowledges that the distinction between PTSD-related hypervigilance and depression-based paranoia may be nothing more than diagnostic artifice. Treatment aimed at either may substantially affect the other. Riggs (2000) addresses the potential interactions in the etiology and maintenance of both PTSD and OCD symptoms. It is plausible (if not likely) that exposure to trauma memories might exacerbate certain obsessions and compulsions that may also have their origins in Vietnam. Such unexpected effects necessitate that assessment be ongoing and flexible. In Howard's case, one might want to monitor physical complaints, depression, rituals, and memories both within and between sessions. This may seem labor-intensive, but the data produced will be essential for guiding future interventions (see Kimble et al., 1998, for one model to monitor symptom changes). Bufka (2000) adds that monitoring not only symptoms but cognitions would be necessary in treating Howard's depression.

Multidisciplinary Treatment

The complexity and chronicity of Howard's symptoms suggest that the best treatment would involve multiple professionals (Bufka, 2000). Besides individual psychotherapy, Howard would benefit from psychopharmacological intervention to aid with anxiety and depression, regular medical visits to monitor somatic complaints, and group treatment to dispel his isolation and paranoia. Ideally, all of this treatment would occur in the context of a clinic in which information can be shared among providers (Kimble et al., 1998). The presence of medical and mental health providers within the same clinic would allow for easy communication within and among disciplines. If Howard's case is handled by a multidisciplinary treatment team, then interventions at one level (and their expected implications) can be communicated to all providers. In cases like Howard's, where numerous professionals are likely to be involved, an appropriate referral to a local clinic where comprehensive services are available may be the first step toward good treatment.

Summary

This clinical commentary summarizes the thoughts of Bufka (2000), Otto (2000), and Riggs (2000) on the case of Howard, a 51-year-old Vietnam combat veteran who presents with multiple comorbid diagnoses. In 1965, at the age of 18, Howard was a conscientious, athletic, and idealistic youth who enlisted in the Marines immediately out of high school. In 1998, at the age of 51, Howard was prone to sickness, emotionally defeated, and haunted by numerous psychological concerns.

Despite Howard's many concerns, all three commentaries were optimistic that Howard could improve his quality of life. Emphasis was placed on the appropriate utilization of validated treatments for depression, PTSD, and OCD within the broader context of a complex case in which multiple complaints are present. This multifactorial approach led to discussions about the importance of patient preparation for treatment, the necessity for initial and ongoing functional assessments, the value of utilizing patient strengths, the significance of acknowledging the interplay among symptoms, and the advantages of multidisciplinary treatment.

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