The Case of the Tumbling Tumbleweed

Multiple Comorbid Conditions and
the Use of Supportive Factors

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Abstract: Thus far, the literature in psychotherapy research on the relationship between specific factors and treatment outcome has focused on discrete, well-defined disorders. In contrast, this case study reviews a man who presents with a complex diagnostic picture. As a result, the student clinician drew from the literature examining the role of common factors, specifically of a supportive nature, in psychotherapy outcome. The client exhibited features from a variety of both Axis I and Axis II ailments, including alcohol dependence, sexual masochism, paraphilias, and borderline personality disorder. The challenges of case conceptualizing and treating an individual exhibiting multiple comorbid conditions are presented.

Keywords: case study; assessment; borderline personality; alcohol dependence; racism

I THEORETICAL AND RESEARCH BASIS

The following case study describes the course of treatment for a man with a complex diagnostic presentation. In turning to the literature for guidance in treatment planning, it quickly became apparent that research on the efficacy of treatment modalities typically focus on discrete diagnoses with few, if any, comorbid mental health conditions. Nevertheless, a review of the psychotherapy outcome literature did provide a general course of direction with which to initiate the process of psychotherapy; thus, a summary of the relevant literature findings is offered here.

Some of the studies in the psychotherapy outcome literature suggest that for certain well-defined diagnoses (depression, for example), specific therapy interventions...
may be indicated (e.g., Dobson, 1999; Miller & Berman, 1983; Stevens, Hyman, & Allen, 2000). Unfortunately, the methodological constraints inherent in researching treatment outcome within the context of multiple, comorbid mental health diagnoses (e.g., small sample size, improper control conditions, lack of standard treatment protocols, and so forth) have thus far precluded researchers from studying the role of specific therapy interventions with psychodiagnostically complex populations.

In the absence of a specific literature to guide the treatment of this individual, the literature review turned to a body of psychotherapy outcome research suggesting that most of the various specific therapies share common factors and that these common factors may serve as active ingredients in bringing about positive change. One of the first such studies on these common factors used behavioral and affective checklists describing clinicians (Lorr, 1965); 523 clients completed the checklists. A factor analysis of the data identified five therapist factors. Subsequently, scores on these factors were correlated with client and therapist ratings of improvement. The client ratings of understanding and acceptance by their treating clinician were most highly correlated with both client and therapist improvement ratings. Cooley and LaJoy (1980) later replicated these findings. In a study more closely related to some of the issues in the case study presented here, Miller, Taylor, and West (1980) found that variations in specific interventions with problem drinkers did not result in significant outcome differences; however, a strong relationship between therapist empathy and client outcome did emerge.

Furthermore, Bergin and Garfield (1994) hypothesized that elements common across specific therapies could be thought of as aligned into the following three factors: support components, learning components, and action components. The support components include elements such as therapeutic alliance, therapist warmth, genuineness, empathy, respect, and acceptance. Learning elements common across specific therapies include feedback, insight, advice, and exploration, whereas action components are characterized by risk-taking, behavioral regulation, and mastery efforts. The research literature on common factors has primarily focused on the role of what Bergin and Garfield termed supportive components. For example, a meta-analysis, including 24 studies examining the relationship between measures of therapeutic alliance and client outcome, revealed that the alliance is predictive of subsequent client outcome (Horvath & Symonds, 1991).

It is hoped that future research may someday overcome inherent methodological challenges and offer more guidance on the specific factors that can bring about change in the psychodiagnostically complex client. In the absence of any such current research body, the course of treatment in the present case study was guided not only by the results of a comprehensive clinical assessment but also by the research findings on the importance of the supportive common factors. The treating clinician was at all times vigilant to remain genuine and warm while communicating acceptance.
2 CASE PRESENTATION

Mr. V, a 55-year-old Caucasian, did not present with any particular concerns on the first meeting with the student clinician. Rather, the case manager assigned to Mr. V requested that Mr. V be seen because of “inappropriate” behavior during biweekly group counseling sessions for substance abuse held by the case manager. Mr. V had made sexually suggestive remarks to the other group members as well as the case manager, resulting in a somewhat hostile group environment. Despite his lack of presenting complaints, Mr. V arrived 10 minutes early for his first appointment and stood at a distance unobtrusively peering into the female clinician’s office without announcing himself until he was addressed.

3 HISTORY

Mr. V is the oldest of two boys born to his parents. His mother was married at least 10 times in her lifetime whereas his father was married a minimum of 5 times. Mr. V initially lived with his mother and his younger brother following his parents’ divorce. During middle childhood, a male, teenage cousin frequently babysat for him and his brother. This cousin repeatedly sexually abused Mr. V and his brother over a period of several weeks to months. Mr. V felt some jealousy because he noticed that the perpetrator “preferred” to sexually assault his younger brother. Mr. V found some of the abuse pleasurable and some painful, but the perpetrator would give him alcohol to ease the pain. Mr. V disclosed the abuse to his mother and was sent to live with his father as a result. He experienced distant or poor relationships with the multiple stepmothers that entered his life while living with his father. Mr. V engaged in some consensual homosexual experiences as a teenager while intoxicated. He has been in only one long-term intimate relationship, a homosexual relationship that began at the age of 17. Mr. V remained in that relationship for 14 years. He has not had any intimate relationships with women, but would like to at some point so that he would know what it is like.

Mr. V served in both the Army and Navy. While in the Army, he served in Vietnam and later in the United States. On several occasions while in Vietnam, he awoke to the sound of gunshots outside his bunker. Subsequently, he began sleeping outside because he no longer felt safe sleeping inside. Mr. V did not experience any direct contact with the enemy during his service in Vietnam. Mr. V was honorably discharged from the Army.

Mr. V was assaulted while in uniform on his return home. He was beaten by a group of males who took turns urinating on him. It was late when Mr. V arrived home, so he went to sleep without showering out of fear that the shower would awaken his parents who would then find out what had happened to him. Mr. V began engaging in unusual sexual practices after that point. He began encouraging others to urinate on him as a way to increase his arousal. He enjoyed being bound and beaten. He began eating feces as
well and enjoyed being forced to engage in these acts. Mr. V repeatedly engaged in sexual acts with people he did not know. On initiation of the current treatment, Mr. V's extensive sexual fantasy life revolving around masochistic and/or sadistic themes interfered substantially with his daily functioning (e.g., it would take him up to 3 days to complete one fantasy, eliminating all activities to create time for additional fantasizing, and so forth). In addition, Mr. V has been robbed and beaten eight times in the past 2 years by people he did not know.

Three years after his Army discharge, Mr. V enlisted in the Navy. He reportedly enlisted because he felt the Navy would help him regain physical fitness and provide him with employment. Mr. V's assigned ship was soon ordered to go to Vietnam. Mr. V became intoxicated and told a chaplain that he was going to kill a superior officer to avoid going to Vietnam. The chaplain intervened in the situation, and Mr. V received his first treatment for alcohol dependency. On a previous occasion, Mr. V became angry and poured a large quantity of a potentially lethal substance into a superior officer's coffee. Another individual saw Mr. V commit this act and successfully intervened. Mr. V was discharged following his alcohol-dependency treatment; he has held more than 30 jobs, mostly custodial in nature, since his discharge from the service.

Mr. V experienced emotional distress, primarily intense anger and intrusive recollections, at military ceremonies or holidays. However, Mr. V did not engage in any avoidance behaviors to control his exposure to these external cues. In fact, Mr. V actively sought out opportunities to witness military-related ceremonies and read books detailing wartime traumatic events. These would invariably lead to increased anger, violent fantasies, and nightmares.

Following his service years, Mr. V completed two more treatment programs for alcohol dependency. His longest period of sobriety was more than a decade. Mr. V relapsed within the past couple of years after he lost contact with his long-term AA sponsor. He continued to work intermittently at janitorial or food service jobs. He was without work frequently and became homeless. Mr. V remained homeless even when he was working and being paid. Mr. V found that he preferred to sleep outside because he slept more peacefully and did not have nightmares. He learned to sleep on his left side without moving so that his dominant hand remained free and he could defend himself if necessary. When entering the current residential treatment setting, Mr. V believed he was having nightmares from sleeping inside but could not recall the dreams during his waking hours. He often awoke with his sheets soaked with perspiration and dislodged from the mattress.

Mr. V came to the area several months ago after impulsively deciding to travel across the country with a friend he had recently met. After reaching the area, Mr. V became aware that his friend had lied to him about being in the military. Mr. V was disillusioned by his friend and as a result severed the friendship; however, he was now in a part of the country that he was unfamiliar with and had no financial resources or place to stay. Mr. V lived on the streets until it got cold outside and then voluntarily entered an inpatient mental health facility for detoxification. Mr. V was released to a shelter follow-
ing detoxification. While living at the shelter, Mr. V became angry at his treatment by the other residents and the staff. He began drinking again, which was against shelter policies. Mr. V was again admitted for detoxification. Following detoxification, he was admitted to the present residential treatment program for treatment of his alcohol dependency.

4 ASSESSMENT

Mr. V obtained a T-score of 46 on the verbal scale and a T-score of 48 on the abstraction scale of the Shipley Institute of Daily Living Scale. Both the verbal and abstraction scores are within the average range. Based on these scores, Mr. V’s estimated full-scale WAIS-R IQ is 90 (± 9), which falls in the low average to average range of intellectual ability. Mr. V’s achievement scores on the Wide Range Achievement Test-3 are inconsistent. He achieved a reading score of 86 ± 3.8 (18th percentile, low average), which indicates achievement to be at the eighth-grade level. His spelling score of 67 ± 3.7 (1st percentile, mildly impaired) indicates achievement at the third-grade level. Mr. V’s arithmetic score of 94 ± 4.2 (34th percentile, average) suggests achievement at a seventh-grade level.

On the Bender Visual Motor Gestalt Test (Bender), Mr. V made three errors in 3 minutes and 48 seconds. His errors, calculated with the Lacks scoring protocol, were regresion (figure 2), perseveration (figures 3 and 5), and closure difficulty (figure 4). These errors are associated with emotional indicators but do not fall in the organic range. Based on his performance on the Bender, Mr. V may have a rigid cognitive set and experience difficulty with planning. He may behave in a hesitant manner or have difficulty completing tasks. Mr. V may view interpersonal relationships as difficult. This may result in anxiety or a potential for acting-out aggressively. Mr. V’s responses may further be indicative of poor ego regulation and self-doubt.

Mr. V’s response patterns on the Trauma Symptom Inventory (TSI) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) were consistent; however, he endorsed a high level of infrequent symptomatology. In fact, he endorsed such a markedly high level of atypical experiences on the TSI that the scoring and interpretive guide recommended making no interpretation. The Welsh code for Mr. V’s MMPI-2 profile is as follows: 6871**24*30*95°F*****/LK#

Both the VRIN and TRIN scales were within normal limits. Using the Wiener-Handson Subtle-Obvious subscales, it was revealed that Mr. V clearly responded in a different manner to the Obvious subscales. The total T-score difference of the Obvious-Subtle subscales was 316. All of Mr. V’s scores were highly elevated on the Obvious subscales, but this was not the case on the Subtle subscales. In fact, only the paranoia Subtle subscale demonstrated a moderate elevation.

The Exner system was utilized for both scoring and interpretation of Mr. V’s Rorschach responses. Mr. V’s responses suggested considerable distress. His tolerance for stress and his capacity for control appeared to be about as well developed as most people.
Mr. V's drawings on the Human Figures Drawing Test suggested that in an effort to control and tolerate his distress, he may use regressive defenses.

Mr. V’s Rorschach responses also suggested a high level of conflict between his self-image and his self-value. It seemed that his estimate of personal worth was quite high while his self-image was extremely negative. Mr. V’s responses strongly suggested that both his self-image and self-value are not grounded in reality but based more in imaginary experiences. Mr. V’s Millon Clinical Multiaxial Inventory-II (MCMI-II) profile, which is considered valid, also suggested intrapersonal conflict. Mr. V was elevated on all of the following personality scales: Avoidant, Dependent, Passive-Aggressive, Self-Defeating, Schizotypal, and Borderline. In fact, Mr. V’s scores on these scales all fell within a 13-point range (low = 99, high = 112).

Mr. V’s Rorschach responses suggested that in an effort to deal with his conflicting conceptualizations of himself, he likely further ignored reality. Thus, his formulations of himself were probably quite distorted and negatively affecting his functioning. Furthermore, Mr. V’s responses indicated that he engaged in more negatively focused self-inspecting behaviors than is typical. This likely served to increase his discomfort and self-deprecating behaviors.

Within the interpersonal domain, Mr. V’s responses suggested that he likely viewed the world with a sense of discouragement and doubt, anticipating negative outcomes regardless of any efforts to the contrary. Mr. V’s responses reflected an unusual level of concern for personal space and caution in developing emotional ties with others. He probably behaved in a more defensively withdrawn manner than would be preferable. As with his self-image, Mr. V’s conceptualizations of others were likely more illusory than real. It is worth noting that the only interest in interpersonal exchanges expressed in Mr. V’s responses contained explicit sexual referents.

Mr. V’s responses reflected a very high level of negativity that probably have affected his emotions as well as contributed to perceptual inaccuracies and mediational distortions. His responses reflected a chronic, trait-like negativistic orientation. Based on these findings, Mr. V would be expected to behave in ways that do not coincide with societal expectations or demands, even in situations that are relatively straightforward. At times, his negative emotions may have played a central role in his thinking, whereas, at other times, they may have served as a more peripheral influence. Mr. V’s responses also indicated that he did not modulate his negative emotions as much as most people. He may even have called attention to himself due to the intensity of the expression of his negative emotions. At those times, Mr. V’s behaviors may have been similar to those expected from a child or adolescent. Based on his responses, a potential for asocial or antisocial behavior may have existed, especially if his environment provided little affirmation or positive reinforcement of his high estimate of personal worth.

Mr. V’s responses also reflected inconsistency in his ideations. His responses tended to simplify the stimulus fields and he exhibited a tendency to make highly individualistic responses. Based on these findings, it is likely that Mr. V did not process more subtle cues from either internal or external sources and that his ideation was quite pecu-
liar at times. His responses also reflected rather inflexible and faulty ideational sets that reflected his pessimistic outlook. His ideational style indicated that he probably experienced considerable difficulty reaching decisions and was prone to reversing decisions when he did make them. His response pattern suggested that he makes many errors in judgment, especially when confronted with a problem.

5 CASE CONCEPTUALIZATION

Mr. V presented with a variety of difficulties that are worthy of clinical attention. He exhibited both a tolerance for alcohol and experienced physiological withdrawal symptoms during detoxification. In addition, he was unable to maintain employment or housing as a result of his drinking. Mr. V clearly met criteria for 303.90 Alcohol Dependence, early full remission, in a controlled environment.

The longstanding pattern of engaging in sexual practices that included consensually being bound and beaten by his partners as well as the interference of his sexual fantasies on his functioning was indicative of 302.83 Sexual Masochism. Mr. V’s usage of urine and feces in his sexual practices was best categorized under 302.9 Paraphilia Not Otherwise Specified (urophilia and coprophilia).

It was difficult to determine whether Mr. V was experiencing 309.81 Posttraumatic Stress Disorder (PTSD). He experienced distressing dreams and psychological distress on exposure to events that symbolized military service. He also experienced difficulty sleeping. While in the military, Mr. V threatened to kill someone in a successful effort to avoid returning to Vietnam. However, since leaving the military, Mr. V displayed no sign of avoidance behaviors or numbing of general responsiveness, which is a necessary condition to meet the PTSD diagnosis. Mr. V also displayed irritability; however, his irritability appeared unilateral and may have been present prior to his years of military service. It is possible that Mr. V experienced full-blown PTSD previously and was in partial remission at the time of this treatment.

Mr. V also displayed features of several personality disorders. He engaged in odd behaviors and lacked close friends as would be expected from someone experiencing 301.22 Schizotypal Personality Disorder. Over the course of treatment, it became clear that he was highly suspicious, bore extensive grudges, and consistently felt exploited as would be expected in the course of 301.0 Paranoid Personality Disorder. Ultimately, however, it seemed that the best fit with Mr. V’s personality features was 301.83 Borderline Personality Disorder. It was clear from the testing results as well as from Mr. V’s statements that he had a pervasively unstable self-image. He had a long history of impulsivity in employment, sexual practices, and alcohol usage. Over the course of treatment, Mr. V revealed several other indicators, including threats of self-harm, inappropriate and intense anger, and affective instability.

Mr. V’s recent relapse into alcohol dependence was the focus of the treatment services in his residential program. As a regular part of that program, Mr. V was already
receiving group counseling, vocational rehabilitation, kinescoterapy, psychoeducational groups, and living in a therapeutic milieu. It was felt that these services provided rich opportunities for Mr. V to get feedback on his fluctuating behaviors and work on interpersonal skills. In addition, it was hoped that these services would provide Mr. V with real experiences with which he could create new conceptualizations.

It was decided to offer Mr. V individual therapy as an adjunct to his treatment program and suggested to him that he also see a psychiatrist for evaluation to determine if psychotropic medication might be beneficial. It was anticipated that long-term therapy would be necessary to help Mr. V bring about change. It was felt that Mr. V was best suited to work with a female clinician. It was anticipated that an erotic transference would quickly develop with a male clinician (much as had already happened with his male case manager). However, it was thought that dependency and deprivation themes would also be encountered with a female clinician. It was decided that a focus on the therapeutic alliance might be a highly useful task in therapy as a result. It was hoped that Mr. V's potential for acting out or regression could also be managed effectively within a supportive psychotherapy framework.

6 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Mr. V was seen for 10 weekly sessions. He was consistently early for his appointments and was never absent. At the 1st session, Mr. V clearly stated that he did not have any concerns with his functioning. Mr. V was reminded that he was under no obligation to attend individual therapy; however, the clinician would be willing to work with him to improve the quality of his life should he so desire. Mr. V was asked to give further consideration to whether he had any issues he would like to work on and to contact his case manager if he wished to schedule a session with the clinician at any point in the future. Later the same day, Mr. V scheduled a session.

At the 2nd session, Mr. V articulated several problems that he wanted to work on, including the following: intense anger, sleep difficulties, mood swings, and impulsivity in job and housing changes. When Mr. V was asked what he had tried in the past to deal with these challenges, he revealed several disturbing “solutions.” Among his solutions was an elaborate plan, which he was in the midst of carrying out, to murder three specific people and then commit suicide. Mr. V still had many components of his plan to put into place, but had been making steady progress in his plan over the past months. He envisioned this as “something to look forward to.” The police were contacted, and Mr. V was escorted to an evaluation by a psychiatrist to determine whether to admit him to an inpatient facility.

Prior to contacting the police, Mr. V was reminded of the limits of confidentiality that he had agreed to. While waiting with Mr. V for the police to arrive, the clinician framed the decision to contact the police as an expression of genuine concern for his safety and well-being and thanked Mr. V for sharing these thoughts. Mr. V expressed
anticipatory fear of meeting the police officer but responded quickly to the clinician's assurances that the police officer was not in a punitive role and was also simply concerned with protecting him. The police officer also offered reassurance, and Mr. V accompanied him to the psychiatrist without incident. It was determined by the psychiatrist that Mr. V did not pose an imminent threat, and he was not admitted to the inpatient facility. However, after consultation with a lawyer, it was determined that a duty to warn existed. The intended victims were contacted, and Mr. V was informed of this action. Mr. V expressed disappointment that if he were to carry out his plan in the future, it would no longer be a surprise to the victims; however, he acknowledged that to make effective, long-term changes, he must be completely honest. This chain of events posed an obvious challenge to the therapeutic alliance between the clinician and Mr. V. The clinician met Mr. V following his evaluation by the psychiatrist and processed with Mr. V how the events of the day altered the therapeutic alliance. Mr. V requested to continue in individual therapy with the clinician.

In the 3rd session, Mr. V exhibited some insight into how his racist upbringing influenced his interpretation of the world today. He also stated for the first time that he wished to cease his paraphilia behaviors. Mr. V recognized that those behaviors were incongruent with self-respect and decided independently that he would rather build his self-respect than continue his current sexual behaviors. In the next several sessions, Mr. V shared experiences of feeling angry and his efforts to cope with that anger. He was able to identify a pattern in his coping with anger. First, he would attempt to get other people to solve whatever the situation or problem was. If that did not work, he would spread negative talk about the people he was upset with. If the problem remained unsolved, he would threaten violence. Mr. V found this pattern to be extremely effective and was unsure whether he wanted to change it. At the 6th session, Mr. V came to the realization that his intense anger was typically triggered by situations in which he did not feel his needs were being met. He began thinking about the ways in which he himself was either not meeting or sabotaging his own needs. At this point, Mr. V ceased his planning of future violence (e.g., recall that although he was not an imminent danger at the time of evaluation by the psychiatrist, a few weeks earlier he was nevertheless continuing to plan violence). He began seeking employment, secured an AA sponsor, and sought medical attention for a variety of minor but chronic ailments. Mr. V previously had a history of denying himself medical attention, despite it being available to him free of charge, and he saw seeking appropriate medical treatment as another means of demonstrating increasing self-respect. In addition, Mr. V no longer sought out military-related stimuli. Although Mr. V had made considerable progress, he still had a great deal of work to do. Nevertheless, the student clinician's placement came to an end, and she discontinued working with Mr. V following the 10th session. The student clinician was actually still in placement for nearly 2 more weeks; however, Mr. V felt that he would feel more secure if services were discontinued at a time when he could still "check in" with the clinician if
he needed to. Mr. V did stop by a couple of times to chat with the clinician and say good-bye.

7 COMPLICATING FACTORS

The first complicating factor in the treatment of Mr. V was the need to notify authorities and exercise the duty to warn. The clinician tried to frame the experience of being escorted by the police and evaluated by the psychiatrist as acts of concern for him. Although Mr. V did not enjoy the process, he stated at the time that he did believe the clinician was trying to ensure his and others' safety. Somewhat ironically, Mr. V later referred to that experience as a critical point in the development of the therapeutic alliance. As a result of that experience, he viewed the clinician as someone who took him seriously, respected him, and legitimately cared about him.

Another factor that could be debatable was the role of psychotropic medication in Mr. V's treatment. Two days prior to seeing the clinician and expressing homicidal and suicidal intent, Mr. V was evaluated by a psychiatrist to evaluate whether medication might serve as an adjunct to treatment. At that time, the psychiatrist felt that Mr. V was not in need of medication. The psychiatrist reevaluated the need for medication and/or admission to an inpatient setting after Mr. V's declaration of intent to murder three people and then commit suicide. Although Mr. V was carrying out his plan to harm others, the plan was quite complex and he was not yet near the point of harming anyone. The psychiatrist determined that Mr. V was not an imminent threat to anyone and could therefore be effectively managed in the residential setting. The psychiatrist also determined that the anger and affective inconsistency exhibited by Mr. V was of a characterological nature and thus, in his opinion, not appropriate for any psychotropic medication. Although it seems that Mr. V's treatment progressed without the usage of medication, the decision not to use medication was not universally agreed on by other mental health professionals on the team providing services to Mr. V.

8 FOLLOW-UP

Mr. V decided that he wanted to continue the process he had started. He felt it was very important to get his "mind straight" and stay on the path that he had started. As a result, he resumed regular individual therapy sessions with another student clinician who is of Asian descent. Previously, Mr. V had expressed violent thoughts and urges regarding persons of Asian descent, yet he was able to resume individual therapy without any racial tension toward the clinician. Several months passed uneventfully with Mr. V maintaining employment and saving money; however, within a few days after receiving
a 1-year sobriety award, Mr. V became intoxicated and was consequently discharged from his substance-abuse treatment program for violating his abstinence contract.

9 TREATMENT IMPLICATIONS OF THE CASE

This case study reviews a man who presents with a complex diagnostic picture. He exhibited features from a variety of both Axis I and Axis II ailments. The multiple comorbid conditions presented a challenge to treatment planning. In consulting the literature, it quickly became apparent that psychotherapy outcome research on specific factors has thus far been aimed at examining discrete, well-defined disorders. Other research on common factors as well as the results of testing provided guidance in the provision of treatment services. The clinician tried to draw on the literature suggesting that the supportive factors of psychotherapy may be a key ingredient in effectuating positive change. This was a guiding component throughout the course of treatment; however, it emerged a prominent component at a few key therapeutic points. The first emergence was when the police needed to be called and the duty to warn exercised. Late in the course of treatment, Mr. V himself stated that the clinician's use of supportive factors at that point enhanced the working alliance and aided him in creating positive change. Although he did not state it, it seems likely that the clinician's acceptance, respect, and empathy served as a model for Mr. V as he attempted to develop self-respect and redefine his self-image. Clearly, this achievement was only partially realized during this course of treatment. Mr. V ultimately experienced a lapse in his sobriety. It is hoped that Mr. V's lapse did not lead to a full relapse; 6 months postdischarge, Mr. V had not been admitted for any detoxification treatments.

10 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

An appeal to psychotherapy outcome researchers to address the methodological constraints inherent in psychodiagnostically complex populations to study potentially efficacious-specific interventions is warranted. However, the primary recommendation offered in light of this case study is for students and supervising clinicians to seize the training opportunities presented by complex individuals. Some students, supervising clinicians, or both are tempted to use as training cases only those that present with a straightforward diagnostic presentation with empirically validated treatment protocols available. Certainly, there is high training value in such cases; however, complex cases may also provide unique training value. In this case, working with Mr. V provided the student clinician with the opportunity to grapple with a myriad of training issues in an integrated manner. His complex presentation provided her with the opportunity to conduct a com-
prehensive assessment and work through diagnostic considerations while developing an integrated conceptualization. This assessment experience with Mr. V was invaluable to both an understanding of him as well as in the development of therapeutic rapport. If the student clinician had not conducted the assessment and developed a conceptualization, it would have been much more difficult to communicate genuine acceptance and understanding to Mr. V. His presentation made consulting the research literature an essential step, and this familiarity with the literature will certainly serve the student clinician well in designing future interventions. The issues facing Mr. V also allowed the student clinician opportunities to address both transference and countertransference issues. Although addressing transference issues may not be particularly uncommon in most training experiences, addressing the variety of countertransference was a unique experience to the student clinician. The feelings raised in the clinician as a result of exercising the duty to warn, as well as the feelings related to listening to Mr. V’s sexual practices, provided the student clinician an opportunity to address countertransference issues with valuable supervision and feedback in a supportive training atmosphere. This enabled the student clinician to grow as well. Some of the more difficult training cases may provide a wealth of training experience, and it is hoped that student clinicians and their clinical supervisors will take advantage of the training opportunities such cases present.

REFERENCES


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