



Outline for Written Clinical Case Presentation

❑ **Reason for Referral and Presenting Problem**

Besides referral information, this part should include client's subjective perception of his/her problems and his/her expressed goals for treatment (provide direct quotes if you can). It should also reference the intake information (including the DSM-5 Self-Rated Symptom Measure data when available); ANSA/CANS data; the goals included in the Treatment Plan of Care; and your perception of client's reasons for being in treatment.

❑ **Description of the Client** (*physical, behavioral, and social*)

Age, gender, culture, and primary language as well as level of comfort with the language of therapy. Pt's current situation, including SES, means of support, living situation & significant others. MSE at the first visit (including physical appearance; cognitive, behavioral and emotional presentation; and style of interaction with therapist) and any variations in client's behavior and appearance observed during the course of treatment.

❑ **Brief Pertinent Life History¹**

Family of origin: composition and relationships among family members; social/cultural/SES background; mental illness, substance use & traumas in the family. What is known of patient's early developmental history, significant relationships, and school experiences. Relationship, education, work & leisure pursuits history throughout patient's lifetime. Current family: composition, background, history and relationships. If applicable, include immigration history, relevant medical history (including medications), military service, problems with the law/incarceration; substance use/abuse; and any other significant events. Include any pertinent cultural, class, and social factors that have affected patient's development and functioning.

❑ **Psychiatric History and Past History of Treatment for the Presenting Problem**

Dates, lengths and mode of treatments, including any crises & hospitalization history and precipitating factors if known; medications prescribed and compliance; treatment termination history; patient's perception of past treatments and therapists (include direct quotes if you can).

❑ **DSM-5 Diagnosis**

Should include the "focus-of-treatment" diagnosis, but also any secondary diagnoses and rule-outs. You may add any non-DSM diagnostic impressions if you believe they may be descriptive and helpful. Reference ANSA/CANS, the DSM-5 Self-Rated Symptom Measure data, and any psychological testing data when available.

❑ **Treatment Planning**

Chosen modality and current goals for the treatment; rationale for choosing a particular treatment approach and perceived "fit" between the approach and patient's issues. This part should integrate professional literature/evidence research with patient's diagnosis and background, ANSA/CANS data, Treatment Plan of Care goals, etc.

❑ **Brief Summary of Current Treatment**

Course of treatment: establishment of the therapeutic relationship; emergence of major themes and attempts to address them; termination issues. Mention treatment crises and intrusion of outside factors such as illness, divorce, or moving to a new place. For each phase, give examples of topics discussed; patterns of behavior manifested in therapy and outside of it; salient transference/countertransference issues, and ways of perceiving/relating to the therapist and significant others.

❑ **Monitoring of Treatment Outcomes**

Progress towards agreed upon goals of treatment and any other signs of improvement. This section should include description of how you monitor outcomes, both for your interventions within each session and in the overall treatment.

❑ **Cultural Formulation** (*with reference to assessment and treatment*)

Follow the DSM-5 Outline for Cultural Formulation (OCF)²: Cultural Identity of the Individual; Cultural Conceptualization of Distress; Psychosocial Stressors and Cultural Features of Vulnerability and Resilience; Cultural Features of the Relationship between the Individual and the Clinician; and Overall Cultural Assessment.

❑ **Clinical Case Formulation** (*from any chosen theoretical orientation; include professional literature references*)

Your ideas about how the patient has developed difficulties and what supports maladaptive patterns. For example, you may develop a tentative workup of longstanding personality style (ego-functioning, characteristic defenses, capacity for & type of object relations, major conflicts, etc.) and its developmental antecedents. Conversely, you may focus on cognitive patterns, schemas, and faulty information processes regulating Pt's perception of self and others. Formulation should incorporate cultural factors and draw on your observations of case relational dynamics and hypotheses about the historical origin of the transference/countertransference patterns in the patient-therapist relationship.

❑ **Current Clinical Concerns** (*anything that puzzles you about the case or anything you would like help with*)

This can include: diagnostic considerations; beginning of treatment matters; concerns about "fit" between client and treatment approach; culture-specific clinical issues and treatment modifications; violations of therapeutic frame and boundaries; transference and countertransference issues; treatment decisions you are not sure about; ways to recover from therapeutic mistakes and impasses; treatment dilemmas related to client's substance use; issues related to conducting psychotherapy in conjunction with medication treatment; termination matters, etc.

¹ This biography will inevitably contain an amalgam of your patient's view of their life, accounts by others, and your attempts at reconstruction of their history. Make sure to identify what is your perception vs. the patient's.

² DSM-5, American Psychiatric Association, 2013, pp. 749-750. Further elaboration of the OCF application is provided in the DSM-5 Cultural Formulation Interview (CFI), pp. 750-757 and Glossary of Cultural Concepts of Distress, pp. 833-837