Intern & Trainee Case Conference Presentation Format

I. Purpose

The clinical case presentation provides therapist-presenters an opportunity to hone their professional presentation skills, to build confidence with demonstration of their clinical acumen to a group of colleagues, and to receive peer consultation from other participants along with supervision from the facilitator. It also gives peer-therapists the opportunity to provide consultation, to develop and practice their proto-supervisory skills, and to learn about therapeutic problems, crises, impasses, conflicts, and approaches with clinical cases that are not their own.

Examples of topics within the context of the case presentation include:

- Diagnostic Issues
- Issues of therapeutic frame and boundaries
- "Fit" between client and treatment approach
- Therapeutic crisis or impasses
- Treatment dilemmas related to client's substance use
- Transference and counter transference illustrations and dilemmas
- Culture-specific clinical issues and treatment modifications
- Stage of treatment (e.g., termination) issues

II. Written hand-out

A comprehensive case description (without ANY IDENTIFYING INFORMATION) should be written and distributed to all group members a week prior to the scheduled presentation day. The write-up should integrate multiple sources of data (client's perspective, collateral information, therapist's perspective, case material, data from ANSA/CANS, any other measurements available, etc.) and provide evidence of clinical work and thinking that are supported by professional literature/evidence research. For more details on the format of the write-up, please consult the Clinical Case Presentation Outline. Briefly stating, the write up should cover the following:

- Reason for referral and presenting problem
- Description of the client (physical, behavioral & social)
- Brief pertinent life history
- Psychiatric history and past history of treatment for the presenting problem
- DSM-5 diagnosis (including secondary diagnosis and rule-outs)
- Treatment planning and rationale for choosing a particular treatment approach
- Observations on relational (transference/countertransference) dynamics in the case
- Brief summary of current treatment
- Treatment outcomes and ways of monitoring them
- Clinical Case Formulation (from any chosen theoretical orientation)
- Cultural Case Formulation (using the DSM-5 Outline for Cultural Formation)
- Clinical concerns or issues the presenting therapist would like to address

III. Process Notes

Typed process notes of at least one recent psychotherapy hour (as close to verbatim as possible) are distributed to all participants on the day of the presentation. The notes are presented to the group and discussed in detail (in the light of the case data, clinical and cultural formulation and the issues the presenter asks to address.)

IV. Presentation

Presentations start with questions from the group about any pertinent information that is missing/needs to be clarified in the write-up. Then the presenter takes about 10 minutes to present the case and any additional relevant information since the write-up was completed. The purpose here is to help the group better understand what it is like for the therapist to work with this particular client, rather than merely to go over the written text. The group then asks questions/makes comments that aim to add to the case clinical and cultural formulation. Next, the therapist presents process notes from a recent session. This is followed by a group discussion that focuses mainly on the presenter's stated concerns. In addition, the Director of Training may ask the conference to focus on a particular clinical, cultural, or theoretical issue.