Case Presentation Format

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CASE PRESENTATION OUTLINE

This is a summary outline of headings for your case presentation. The subsequent pages provide greater detail for what may be covered under each of these sections.

Date of Recorded Session:

Counselor Name:

Client Name:

Identifying Data:

Chief Complaint:

Summary of Counseling to Date (including ORS/SRS data):

Personal History:

- Early and middle childhood:
- Late childhood/Adolescence
- Adulthood:

Mental Status:

Risk or Safety Concerns:

Assessment (mental health, relational, spiritual):

Strengths and Protective Factors:

Problems List:

Client Goals:

Theoretical Conceptualization:

Recommended Treatment Plan:

Applicable Community Resources:

Prognosis:

Reason for Presenting Client:

Transcript:

Date of Recorded Session: Date of session to be listened to in class. Also state session XX of XX (e.g. session 7 of 8). Note the treatment setting.

Counselor Name: Your name. If session is done by two or more clinicians include the name of each, noting who lead the interview and who is doing the write-up.

Client Name: Use an alias first name only.

Identifying Data: Include approximate age, gender, ethnicity, marital status (e.g. married, divorced, only-child, lives at home with . . .), occupation, referral source, and whether the client came in on their own, was accompanied by someone else. (1 paragraph)

Chief Complaint: As stated by the patient in their own words, why they have come for assistance at this time—what are some key points or concerns. A statement should be recorded verbatim even if it doesn't make sense in the eyes of the therapist. (1 paragraph)

History of Current Concerns: What is the history of the chief complaint? This information can be obtained by simply asking the question, "How did all this begin?" This section should provide a comprehensive and chronological picture of the events which led up to the current moment. Include information regarding onset of current episode and events that triggered it. Impact of the problems or chief complaint on behavior should be noted. Observations regarding secondary gains can be recorded here also. (2-3 paragraphs)

Summary of Counseling to Date: Briefly summarize your counseling process up to the current session. Include such things as the themes of material discussed in the sessions, client's level of involvement, homework assigned and completed, and how you have handled resistance. Reflect on ORS/SRS outcome data, and comments made by client or supervisor with regard to the therapeutic alliance. (1-2 paragraphs)

Personal History: Concisely describe relevant personal history, important events and milestones, including family of origin dynamics. This section should be supportive of the material in the presenting problem and assessment sections. (1 page)

BELOW ARE SOME SUGGESTIONS FOR AREAS TO COVER:

Early and middle childhood: Conception through age 11. Note unusual circumstances regarding conception and birth. What was the mother-child interaction? What memory themes are present? What words would the client use to describe the family atmosphere and relationships? How did the parents discipline? Favorite games or toys? What is the client's earliest memory? What was the client's early memories of school?

Late childhood: Ages 12 through 18. What was the nature of the client's relationships during this time? What activities did the client engage in? Was there anything which the client considered themselves particularly good at (i.e. sports, musical instruments, academics)? Was the client sexually active? Did the client use controlled or illegal substances? What was the client's role in their family? What does the client remember about school during this period? Where there any particular emotional or physical problems?

Adulthood:

Cultural History: Describe the cultural group(s) with which the client identifies, including color, culture, disability, ethnicity, national origin, gender, race, sexual orientation, or socioeconomic status.

Marital History: Describe history of each marriage, either legal or common law. Also include information regarding other significant relationships. Areas of dissatisfaction in the relationship should be included. For example, issues in parenting, sexuality, housing and management of money should be mentioned. How the client perceives past failures in relationships, what went wrong and who was to blame should also be noted.

Educational History: Did the client finish high school? By degree completion or by GED? Record the number of years of post high school education with competed certificates, diplomas and/or academic degrees. If the client did not complete a particular course of education, for example stopping after completing 3 years of a 4-year degree program, note the reasons for the change.

Military History: If the client has served in the military general adjustment should be commented. Including branch of military, area of service and type of discharge.

Legal History: Include information regarding any arrests, convictions or legal judgments that the clients has been involved with. If the client has been in prison note length of sentence and what the charges were. Comment also on the client's attitude toward his or her legal history.

Medical History: What medical conditions, somatic complaints, accidents, illnesses, hospitalizations, surgeries, etc. has the client experienced?

Occupational History: Record entire employment history including dates of start and finish. Include information regarding reasons for job changes, work-related conflicts, and feelings about current employment situation.

Habits: Note habits including (but not limited to) nail biting, use of nicotine, use of alcohol, use of drugs (both prescription and non), use of caffeine, and sugar consumption. If the client has a history of substance abuse record a current assessment of use.

Past Treatment History: Record any previous treatment for mental health issues. Note both outpatient and inpatient treatment, the duration, the reason for treatment, and the client's assessment of the effectiveness.

Medications: Include a summary of current and past medications. Give attention to all, but special emphasis on any psychopharmacological medications. Record dosage and length of time. Include comments regarding whether the client believes the medications are helping, and any negative side effects.

Mental Status: Comments regarding mental status. (1-2 descriptive paragraphs)

BELOW ARE ITEMS TO CONSIDER INCLUDING:

Appearance: What is the overall physical impression conveyed to the clinician? Comment on body type, weight, height, posture, poise, clothes, grooming, hair and nails. Signs of anxiety, such as sweating and perspiring, tense posture, fidgeting and wide eyes, can be included here.

Psychomotor activity: quantitative and qualitative aspects of behavior including mannerisms, tics, gestures, twitches, stereotyped behavior, echopraxia, hyperactivity, agitation, combativeness, flexibility, rigidity, gait, restlessness, wringing of hands, pacing and other physical manifestations.

Attitude: The client's attitude toward the examiner should be noted.

Mood: Note whether the client offers a description of mood or whether it is the impression of the clinician. Include statements regarding depth, intensity, duration and fluctuations.

Affect: Patient's present emotional responsiveness. Examples include: blunted, constricted, flat, expansive or within normal range. Also note whether the emotional responsiveness seemed appropriate to the subject matter.

Speech: Can be described as in both quality and quantity. Talkative, voluble, unspontaneous, rapid, slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato or mumbled are all ways to describe client speech. Unusual characteristics such as accent or rhythms should be noted.

Perceptual disturbances: Hallucinations and illusions are noted here. Note whether they are auditory, visual, olfactory or tactile. Circumstances and content should be described. Example question: Have you ever heard voices, seen visions or had strange sensations that others did not seem to experience?

Thought: Comment on thought process (how a person thinks) and thought content. Persistent negative thoughts, flight of ideas, racing, tangential, circumstantial, incoherent, and thought blocking are all common descriptions of thought process. Common description of thought content includes delusions, paranoia, preoccupation, obsessions, compulsions, phobias, suicidal, ideas of reference and poverty of content.

Sensorium and Cognition: Please comment on the client's consciousness, orientation, memory, capacity to read and write, visuospatial ability, abstract thinking and fund of information by summarizing any remarkable findings from the results of the Mini-Mental Status Exam (MMSE).

Impulse control: Record whether the clients seems able to control sexual, aggressive or other impulses.

Judgment and insight: With regard to judgment can the client understand consequences to behavior? Are they able to predict what might happen and make decisions based on that information? Concerning insight comment on the client's level of self-awareness, ability to recognize internal motivations and the level to which they take responsibility for their situation.

Reliability: Estimate the level to which the client appears to be a reliable source of information and their ability to report their situation accurately.

Daily Activities: What are they doing; how well; any reduction in functioning, etc.

Risk or Safety Concerns: Suicidal or homicidal ideation or behavior, self-harming behaviors, or reporting issues.

Mental Health Assessment: Include this section on the professor's copy only. Present a comprehensive DSM 5 diagnosis, with principle diagnosis listed first. Important: The diagnosis should be evident from the write-up narrative sections, and the treatment plan should naturally flow from the diagnosis. This should include both symptoms reported and symptoms observed. An experienced clinician should be able to accurately guess the diagnosis based on reading the treatment plan. Please also include notation regarding any dual diagnosis.

For the primary diagnosis please articulate clearly the exact criteria from the DSM V that you believe supports your diagnosis.

Relational Assessment: What is the client's history and current involvement with regard to friendships, social groups, participation in community activities, volunteerism, and community organizations. How do their current relationships impact their functioning?

Spiritual Assessment: Describe the client's spiritual life and the nature of their relationship to faith. Include any information on whether they find faith a help or hindrance, their understanding of God, sources of hope, areas of spirituality where they have indicated a need for growth. What is the client's view of God? Does the client currently attend a church or religious meeting? Did the client's parents encourage or discourage religious involvement? How do the client's religious or spiritual beliefs help or hinder them? What does the client's religious beliefs say about counseling? (1-2 paragraphs)

Strengths and Protective Factors: What's going well? Comments regarding client strengths can come from client's self statements and clinician's observations. Note such things are personality strengths, relational strengths, skills and job qualifications, positive family and social support, and client hopefulness.

Problems List: List, in order of assessed importance, client's problems. This information can be based on such a question as, "What are your top three problems right now?" The list recorded here may also include additions by the clinician. Add a note to each concerning whether it was a client self statement or a clinical observation. For example, 1. Depression (client) 2. Job situation (client) 3. Self-esteem (counselor). The list should not be longer than 6 items.

Client's Goals: In the client's own words record what the goals for treatment are. The question may be phrased similar to the following: "How do you think counseling could be helpful for you?"

Theoretical Conceptualization: Indicate the theoretical orientation you are operating from and why you have chosen that orientation for this client. Include a brief discussion describing how you conceptualize this client and presenting problem from your chosen theory. (1-2 paragraphs)

Recommended Treatment Plan: Include larger more long term goals (e.g. Client will report reduced severity of symptoms) as well as smaller objectives and short-term goals (e.g. Client will complete daily positive events; client will learn and practice two effective and healthy coping techniques.) Note recommendations for type of treatment, duration, need for adjunct services (i.e. support groups, church or family involvement, suicide agreements, psych testing, physical evaluation, medication, etc.).

The adjunct services should include both interdisciplinary (i.e. medical referral, art therapy, occupational therapy) and community resources (i.e. support groups such as AA, Celebrate Recovery, etc.).

Your treatment plan should include goals, objectives and methods. (one-half page) The goals must be specific, measureable, action oriented, reachable and time-specific.

Applicable Community Resources: Include a list of potential community resources that may assist the client in achieving their treatment plan goals.

Prognosis: Record your opinion regarding the probable outcome of treatment for the current disorder/problem. Briefly (1-2 sentences) support your prognosis with known positive and/or negative factors.

Reason for Presenting Client: Include your thoughts on transference and countertransference. What challenges do you face? Comment on why you have chosen this particular client to present and what help you desire from the group. With regard to the help you desire make your request specific. (1 paragraph)

Transcript: The transcript section should be 20 minutes long. Pages should be divided into two columns. The left hand column should contain the text of your counseling session. The right hand column should include your explanations, assessments and evaluations of what is transpiring in the tape. *Emphasis in grading will be placed on your ability to identify such things as thinking errors, feelings, developmental issues, transference and countertransference.* Identify individuals mentioned in the tape and number the responses. Be sure to rate your responses according the system adapted from Gazada et.al.

Each transcript presentation must include at least one interaction that you feel you handled well and one interaction that you feel you did not handle well (this may require breaking up the transcript using two sections of tape). *Mark these two sections with statements in the right hand column: Handled well and Needed improvement*. In the right hand column provide an analysis of what you felt you did in each section that was helpful or not helpful.

TRANSCRIPT

Individuals mentioned: Sue is the client, Tom is her husband from whom she is separated, Bob is her boyfriend.

Verbatim Transcript	Interpretive Analysis
Co.1: Hi	Our sessions often start with catch up. I have worked to get the client to dig right in to the material for the session.
Cl.1: Hi, how are you?	
Co.2: Good! Well, what would you like to talk about today?	I deflected her question about myself and asked what she wanted to discuss. (CF2)
Cl.2: I've had a really tough time this week. Tim is putting me through a really difficult time with the divorce stuff. I got really angry and went over to his work and we had this big scene and all. It was pretty disgusting.	She has had trouble containing her behavior. It is not uncommon for her to follow her husband around and to argue in parking lots, at work etc.
Co.3. Sounds frustrating . . .	Reflective statement (E2)
Cl.3: Yeah, it was. I've really had it with him and all his garbage. He is so irresponsible.	She likes to blame him and go on and on with this.
Co.4: He still isn't following through on agreements?	I should have focused on her, instead I get caught in the trap of discussing him. What follows in Cl.4 is a result. (C1)
Cl.4: No!! (raising her voice and pounding her fist on the arm of the couch) He never does, it infuriates me so much	
Co.5: How have you handled your anger over this?	Attempting to get back on track. (C2)
Cl.5: Ok, I guess. I didn't hit him or anything.	She tends to minimize her behavior.
Co.6: What about going over to his work. Was that something you felt was helpful?	I attempt to confront her minimization. (CF2)
Cl.6: No, I guess it wasn't, but I didn't have a choice!	