

Case History, Formulation, and Treatment Plan

I. Case History (Suggested # of words: 750)

General Instructions: The case history should briefly summarize the most important background information that you collected in evaluating this patient for treatment. Be succinct in describing the case history.

A. Identifying Information

Provide a fictitious name to protect the confidentiality of patient. Use this fictitious name throughout the Case History and Formulation. Describe patient's age, gender, ethnicity, marital status, living situation, and occupation.

B. Chief Complaint

Note chief complaint in patient's own words.

C. History of Present Illness

Describe present illness, including emotional, cognitive, behavioral, and physiological symptoms. Note environmental stresses. Briefly review treatments (if any) that have been tried for the present illness.

D. Past Psychiatric History

Briefly summarize past psychiatric history including substance abuse.

E. Personal and Social History

Briefly summarize most salient features of personal and social history. Include observations on formative experiences, traumas (if any), support structure, interests, and use of substances.

F. Medical History

Note any medical problems (eg., endocrine disturbances, heart disease, cancer, chronic medical illnesses, chronic pain) that may influence psychological functioning or the treatment process.

G. Mental Status Observations

List 3-5 of the most salient features of the mental status exam at the time treatment began. Include observations on general appearance and mood. Do not describe the entire mental status examination.

H. DSM IV Diagnoses

Provide five Axis DSM IV diagnoses.

II. Case Formulation (Suggested # of words: 500)

General Instructions: Describe the primary features of your case formulation using the following outline.

A. Precipitants:

Precipitants are large scale events that may play a significant role in precipitating an episode of illness. A typical example is a depressive episode precipitated by multiple events, including failure to be promoted at work, death of a close friend, and marital strain. In some cases (eg., bipolar disorder, recurrent depression with strong biological features) there may be no clear psychosocial precipitant. If no psychosocial precipitants can be identified, note any other features of the patient's history that may help explain the onset of illness.

The term *activating situations*, used in the next part of the Case Formulation, refers to smaller scale events and situations that stimulate negative moods or maladaptive bursts of cognitions and behaviors. For example, the patient who is depressed following the precipitating events described above may experience worsening of her depressed mood when she's at work, or when she's with her husband, or when she attends a class she used to attend with her friend who died.

Which *precipitants* do you hypothesize played a significant role in the development of the patient's symptoms and problems.

B. Cross-sectional view of current cognitions and behaviors:

The *cross-sectional* view of the case formulation includes observations of the predominant cognitions, emotions, behaviors (and physiological reactions if relevant) that the patient demonstrates in the "here and now" (or demonstrated prior to making substantive gains in therapy). Typically the cross-sectional view focuses more on the surface cognitions (ie., automatic thoughts) that are identified earlier in therapy than underlying schemas, core beliefs, or assumptions that are the centerpiece of the *longitudinal* view described below.

The *cross-sectional* view should give your conceptualization of how the cognitive model applied to this patient early in treatment. List up to three current activating situations or memories of activating situations. Describe the patient's typical automatic thoughts, emotions, and behaviors (and physiological reactions if relevant) in these situations.

C. Longitudinal view of cognitions and behaviors:

This portion of the case conceptualization focuses on a *longitudinal* perspective of the patient's cognitive and behavioral functioning. The *longitudinal view* is developed fully as therapy proceeds and the therapist

uncovers underlying schemas (core beliefs, rules, assumptions) and enduring patterns of behavior (compensatory strategies).

What are the patient's key schemas (core beliefs, rules, or assumptions) and compensatory behavioral strategies? For patients whose pre-morbid history was not significant (eg., a bipolar patient with no history of developmental issues that played a role in generation of maladaptive assumptions or schemas) indicate the major belief(s) and dysfunctional behavioral patterns present only during the current episode. Report developmental antecedents relevant to the origin or maintenance of the patient's schemas and behavioral strategies, or offer support for your hypothesis that the patient's developmental history is not relevant to the current disorder.

D. Strengths and assets

Describe in a few words the patient's strengths and assets (eg., physical health, intelligence, social skills, support network, work history, etc.).

E. Working hypothesis (summary of conceptualization)

Briefly summarize the principal features of the working hypothesis that directed your treatment interventions. Link your working hypothesis with the cognitive model for the patient's disorder(s).

III. Treatment Plan (Suggested # of words: 250)

General Instructions: Describe the primary features of your treatment plan using the following outline.

A. Problem list

List any significant problems that you and the patient have identified. Usually problems are identified in several domains (eg., psychological/psychiatric symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure). Problem Lists generally have 2 to 6 items, sometimes as many as 8 or 9 items. Briefly describe problems in a few words, or, if previously described in detail in the HPI, just name the problem here.

B. Treatment goals

Indicate the goals for treatment that have been developed collaboratively with the patient.

C. Plan for treatment

Weaving together these goals, the case history, and your working hypothesis, briefly state your treatment plan for this patient.

IV. Course of Treatment (Suggested # of words: 500)

General Instructions: Describe the primary features of the course of treatment using the following outline.

A. Therapeutic Relationship

Detail the nature and quality of the therapeutic relationship, any problems you encountered, how you conceptualized these problems, and how you resolved them.

B. Interventions/Procedures

Describe three major cognitive therapy interventions you used, providing a rationale that links these interventions with the patient's treatment goals and your working hypothesis.

C. Obstacles

Present one example of how you resolved an obstacle to therapy. Describe your conceptualization of why the obstacle arose and note what you did about it. If you did not encounter any significant obstacles in this therapy, describe one example of how you were able to capitalize on the patient's strengths in the treatment process.

D. Outcome

Briefly report on the outcome of therapy. If the treatment has not been completed, describe progress to date.