

CASE WRITEUP EXAMPLE

December 2, 1998

- I. CASE HISTORY [actual word count: 774] (suggested # of words: 750)**
- A. Identifying Information:** Ann is a 44-year-old, twice-divorced, Caucasian woman who has no children, lives alone, and has been working full-time as a Spanish teacher for the past 22 years.
- B. Chief Complaint:** Ann sought treatment due to an escalation in her depression which started in October, 1996. She reported that she was also binge eating and overusing and abusing laxatives at least once a week, though she was much more concerned by the depression than the eating/laxative problem.
- C. History of Present Illness:** In October, 1996, Ann divorced her second husband and began to develop depressive symptoms (sadness, crying, social withdrawal, severe self-criticism). The depression worsened until it reached the severe level in March, 1997. At intake (May, 1997), her symptoms included the following:
- emotional symptoms: sadness, anxiety, lack of interest in almost all activities
 - cognitive symptoms: difficulty concentrating, believing she was worthless and unloveable
 - behavioral symptoms: crying, social isolation

physiological symptoms: difficulty falling asleep, tiredness

She developed subclinical symptoms of bulimia nervosa in April, 1997. At intake, she reported that she binged, felt out of control of this behavior, and overused laxatives about once a week; she was (and is) intermittently preoccupied with a misperception that she is fat and is highly self-critical.

The major stressors in Ann's life are social ones. Since her divorce she has withdrawn from friends, family, and co-workers. She has dated several times since her divorce but each date has been a "one-night stand," which leaves her feeling rejected and defective. She used to derive significant satisfaction from relationships but has isolated herself and now feels sad, lonely, and rejected by others. While she finds it more difficult to do her job, work does not appear to be a significant stressor.

Ann restarted Prozac about 2 weeks ago (prescribed by her family physician) but thus far sees no change in her depressive symptoms.

D. Psychiatric History: Ann's first episode of major depression occurred in 1977 when her first husband divorced her. She was hospitalized for three weeks and was given Elavil. She discontinued the medication (against medical advice) at discharge but initiated psychological treatment (cognitive therapy) for the first time. Her depression remitted after four months of this outpatient psychotherapy, though she remained in therapy on a biweekly basis for another year, working on Axis II issues.

In 1989, Ann and her second husband received about six sessions of (predominantly psychodynamic) marital counseling which she found “mildly helpful.”

In October, 1996, Ann’s family physician prescribed Prozac which initially helped reduce her depressive symptoms. The depression worsened in December, 1997, and she discontinued the medication on her own.

E. Personal and Social History: Ann grew up the middle child of three. Her parents were Italian immigrants and her mother did not speak English. Ann considered herself the “ugly duckling” of the family. Her older sister was considered thin and pretty while Ann was called “chubette” and “big nose.” She felt as if she were an extra burden to her family since they strongly wanted a boy when she was born. Her younger brother was born 18 months later and received nearly all the family’s attention. She describes her father as having been strict, controlling, demanding, and very concerned about what others thought of him. She describes her mother as quiet, unhappy, not affectionate, and old-fashioned. Ann felt unloved and unable to measure up to her siblings.

Ann attended Catholic school where she reports being trained to be “the perfect soldier.” She married for the first time at age 18. She reports that she was abused and controlled by her first husband who was violent at times. She believed she deserved the abuse and submitted to his wrath. When she finally got the courage to leave the marriage, she did not have her family’s approval and to this day resents their lack of support.

Ann remarried in 1989. Her second husband reportedly spent a lot of time with young men and Ann suspects he was bisexual. He ceased having any sexual relations with her about three years after their marriage. Though they tried marriage counseling briefly, her husband was unwilling to work on modifying the situation and they divorced in October of 1996.

F. Medical History: Ann did not have any medical problems which influenced her psychological functioning or the treatment process.

G. Mental Status Check: Patient is fully oriented, with depressed mood.

H. DSM IV Diagnoses:

Axis I: Major Depressive Episode, Recurrent, Severe

Rule out Bulimia Nervosa

Axis II: Avoidant Personality Disorder

Axis III: None

Axis IV: Divorce, Multiple Relationship Failures

Axis V: GAF Current—68. Best in Past Year—80.

II. CASE FORMULATION: [actual word count: 403] (suggested # of words: 500)

A. Precipitants: Ann's second divorce probably precipitated a recurrence of depression. Although it was she who initiated the divorce, she nevertheless felt

rejected, believing that if she were more loveable, her husband would have fought to save the relationship. Feeling not only unloved by and unloveable to her husband but also unloveable in general, she began to isolate herself. She was no longer getting much positive input from her friends, family, and co-workers because of her lack of contact with them—but, like the divorce, she perceived this self-initiated reduction of contact as their rejecting her, instead of her withdrawing from them. She became increasingly sad and lonely and other depressive symptoms began to develop.

B. Cross-Sectional View of Current Cognitions and Behaviors:

A typical current problematic situation is that Ann has just had sex on the first date with a man. Lying in bed with him she has the automatic thoughts, “I’m so ugly, what does he see in me, he’ll never call, I might as well get up and leave now.” Emotionally she feels sad and her behavior is to leave abruptly (probably appearing unfriendly, at best, to her date). A second typical situation is that she’s reflecting on how a man has not called her back after a date. Her automatic thoughts are, “I’m too fat. No one wants me.” She then feels sad, binges, and takes laxatives. A third situation is attending a family dinner where she perceives her father as being critical about her and her mother as lacking affection. She thinks, “No one cares about me; there’s something wrong with me, I’m unimportant.” She feels sad and becomes monosyllabic, speaking only when spoken to.

C. Longitudinal View of Cognitions and Behaviors:

Ann grew up with non-English speaking Italian immigrant parents: a father who was demanding and critical and a mother who was emotionally distant. Early on she developed the belief that she was defective and unloveable, beliefs that were strengthened by the attention heaped upon her younger brother, by increasing academic expectations of her father, by the criticisms of her teachers, and by her self-comparisons to her more attractive older sister. She developed the following key assumption: “If I’m perfect, don’t cause trouble, and try always to please others, they’ll like me. If I don’t, they’ll find me unloveable.” Her compensatory behavioral strategies included being overly compliant, submissive, “perfectly” behaved, and avoidant of conflict.

D. Strengths and Assets

Ann has had many years of success in her professional life. In her role as teacher, she is extremely well-liked by her students, and given high praise from her peers.

E. Working Hypothesis (summary of Conceptualization)

It is understandable that Ann came to view herself as unlovable and defective as a result of the circumstances of her childhood. Being the daughter of highly demanding, critical European parents, her strict parochial education, and her abusive marriages, laid the foundation and then reinforced her negative view of herself. This negative self view is typically activated in interpersonal situations where she perceives rejection.

In order to function in the world, she has established rigid assumptions for herself: i.e., “I must be perfect or people will reject me,” “I must please others, or they

C. Plan for Treatment:

The treatment plan was to reduce Ann's depression through helping her respond to her automatic thoughts (especially those connected with unloveability) and activity scheduling (especially to increase socializing). We also worked on alternative behaviors to bingeing when she was upset. Next, we tested her assumptions about being rejected if she displeased people and then worked on assertiveness skills. We are currently working at the belief level, modifying her view of herself as unloveable and defective.

IV. COURSE OF TREATMENT [actual word count: 300] (suggested # of words: 500)

A. Therapeutic Relationship: Treatment was facilitated by Ann's eagerness to please ("If I please others, they'll like me") but the counterpoint to this assumption ("If I disagree with people, they won't [like me]") did interfere slightly. Ann was too eager to please in therapy; she quickly agreed with me, sometimes without really stopping to reflect on the hypotheses or alternative perspectives I presented to her. I was able to elicit from her another belief ("If I tell someone I disagree, they'll take it as criticism"), helped her test these beliefs with me, correct her thinking, and then she became more willing to tell me when she didn't fully understand or agree with what I had said.

B. Interventions/Procedures:

1. Taught patient standard cognitive tools of examining and responding to her automatic thoughts (which allowed the patient to see her dysfunctional distorted logic and thus significantly reduced depressive and anxious symptoms.)
2. Had Ann conduct behavioral experiments to test her assumptions (e.g., If I say no to a man about having sex on a first date, he'll get mad and never call me again.). This resulted in reduced avoidance and increased assertiveness.
3. Had Ann keep an ongoing log of evidence that she was a loveable person, which helped her modify a key core belief.

C. Obstacles: When Ann had a bad week, she became hopeless about therapy. We reframed her setback as a reactivation of her schema due to an unfortunate incident with a date and as an opportunity to practice responding to negative automatic thoughts and solidifying a new, healthier belief.

D. Outcome: Ann's depression gradually reduced over a four month period after we started therapy, until she was in full remission. She remains in therapy to work on lingering problems with male relationships and her self-image.