

Introduction to Case Study Outline

*adapted from document created by J.Cronin and M. Adler

The Case Study Outline is designed to assist students in organizing a professional document to communicate about a particular client. It can be used to convey basic information about a client who has been seen as a 'Case Study' or as a 'Treatment Case.'

This outline will work best if the student and instructor keep the following in mind:

1. **Identifying Data** should be brief and present a clear visual picture of the client's state of being and presentation at 'intake'.
2. **Presenting Problem** is the client's description and view of her/his difficulties and the problems for which she/he consults you.
3. **History of Presenting Problem** helps establish a differential diagnosis. Here you describe the course of the patient's difficulties. Remember, there is a difference between the history of the presenting problem and the client's total life development. The latter belongs in the past history section. It is desirable to establish a specific time when you believe the client's current problems/symptoms began. Describe the onset and course of the patient's symptoms and difficulties which led to the presenting problem. This section will briefly describe the external events and internal processes which converge to overwhelm the client's previously adequately functioning defenses. Taking a careful history here often reveals underlying developmental vulnerabilities which can be described more fully in the next section.
4. **Past History, Relationships, and Current Functioning** describes the essential elements of the developmental history from birth up to the onset of the Presenting Problem. Frequently one finds in the history the underlying vulnerabilities that echo thematically or dynamically the difficulties that eventuated in the breakdown of the defenses that led to the current difficulties. This section also details important relationships in the client's life, both in the past and present. It focuses on the quality and significance of the relationships to the client's development and current life. Relational patterns and capacities should be identified. The client's current functioning should be described as to its fullness and adequacy. Changes in functioning from past to present should be noted.
5. **Course of Treatment** section will be described in some detail for cases in which treatment has been underway for some time. In the Case Study, one will describe the nature of the interactions between the client and the interviewer, and outcome of the interviews.
6. **Formulation** is the most speculative section, and where the writer explains the development of the client's central conflicts/deficits and defenses, and their repetitive effect on behavior. It describes how these conflicts and/or deficits may be activated in treatment. Frequently this is where information about early developmental relationships, current life difficulties, and the relationship to the interviewing therapist are synthesized to form an assessment of the suitability for psychotherapy. "Why did this particular person, develop this particular problem (the role of internal and external factors), at this particular time, and what factors limit or enhance their ability to use therapy to move toward better functioning?"

7. **Diagnosis** this is a short-hand encapsulation of the case formulation. It is best to use the newer Psychodynamic Diagnostic Manual than the DSM if possible.