How to Write a Case Study/Conceptualization/Formulation
(specific assignments will vary depending upon the instructor/course requirements)

- Introduce the person and the reason for referral or treatment

- Provide a description of the client’s current functioning. Make sure the information is presented in an organized fashion so that facts which go together are written in the same paragraph rather than in a “stream of consciousness”. Make sure you include details such as:
  - Age
  - Employment situation, if applicable
  - Living situation
  - Family constellation/connections
  - Medical status: physical condition; diseases
  - Cognitive functioning
  - How long the current behaviors have been persisting
  - Description of presenting symptoms or concerns
  - Client’s understanding of his/her presenting problem
  - Diagnoses, if they have been previously assigned by other clinicians

- Provide some historical information; Describe what you know about the client’s history including biological, psychosocial and cultural considerations
  - Early history; birth family constellation
  - Family history of psychiatric illness
  - Any known history of trauma
  - Educational history and/or occupational history
  - Medical history
  - Cultural background or other identity factors such as gender, sexual preference, age factors that may be related to current functioning
  - Any previous treatment

- DSM diagnosis and rule outs
  - Explain why the client meets diagnostic criteria
  - Note “rule outs” (i.e., other diagnoses with similar symptom presentation that you have ruled out or which still need to be ruled out); Explain your reasoning.

- Present conceptual reasoning: For some courses you will be asked to explain your understanding of the case from a theoretical perspective you have studied. For example,
you might discuss/explain your understanding of the client’s behaviors from the perspective of attachment theory or psychoanalytic theory.

- Discuss **risk and protective factors** that might affect treatment. Consider:
  - Social supports: Family, friends, groups
  - Level of motivation to change
  - Prior response to treatment
  - Financial/transportation/time constraints and resources

- Present a **treatment plan** based on what you know about the client, his or her strengths and liabilities and your understanding of the case. Some assignments may also require a prognosis.

**General suggestions:**

- Avoid jargon

- Indicate the source for information you report (“The client reported…”; “hospital records indicate”; “According to a diagnostic intake by Dr. X in June 2012 …”)

- Try not to repeat the same information but “remind” the reader when a particular piece of information is relevant in two parts of the case conceptualization

- Don’t use the client’s name repeatedly in every sentence (use pronouns like he or she) but do use the name again at the beginning of every paragraph or if you have referred to someone else and it is not clear who a pronoun refers to (e.g. *John and his father were at a ballgame. John (rather than “he”) began to feel sad”*).

- Use the present tense when describing current functioning and the past tense for other information

- Make sure all of the information in one paragraph is related and that related pieces of information are presented in sequence rather than listing a series of facts in the order you have them in your notes.
Case Study Map

- Introduce client and reason for referral
- Current functioning
- Historical information: Biological; Psychological; Social
- Assign diagnosis; explain reasoning and rule outs
- Conceptualization of Case
- Strengths and weaknesses re: treatment prognosis
- Treatment Plan