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Case Report Guidelines

This document outlines the academic requirements for writing a case report for the Master of Clinical Psychology (including Post-Registration) program. Competency in presenting psychological data in an integrated and meaningful way is an essential psychological skill as it allows the client's needs to be accurately identified and a tailored treatment plan developed and communicated to other relevant parties.

The purpose of undertaking case reports on placement is to provide students with the opportunity to demonstrate the application of assessment skills learned through the relevant course units. This document should therefore be read in conjunction with relevant assessment material covered in the course program. Specifically, case reports should demonstrate a thorough knowledge of the use of the DSM-5, application of differential diagnosis skills, knowledge of evidence-based treatment for diagnoses, skills in case formulation and the capacity for reflective practice.

General Guidelines

1. Case Reports should consist of approximately 2500 words per case report (no more than 2,750). Case reports must be adequately deidentified and should be based entirely on the students' own direct work with clients seen on placement.

2. Four case reports are required for the Clinical Masters/Doctorate and Post-Registration Clinical Masters. These case reports may either be comprehensive psychological assessment reports or reports on a course of treatment with detailed background history. Amongst the four case reports, one is required to include a cognitive assessment and one include a personality assessment using a standardized assessment tool (e.g., WAIS-IV, WISC, PAI, etc.) taught in the course program (E.g., CLP602, MDT1).

3. Students are required to have their clinical supervisors review and sign off on the reports prior to submission to Canvas.

4. The four case reports should demonstrate breadth of knowledge and skill. Therefore, consider diversity of presenting problem/diagnosis and the nature of the psychological practice applied when choosing cases (i.e., both assessment and intervention skills).

5. Students will be given a pass or fail for this assessment. An opportunity to rewrite a failed case report may be granted. Case reports that do not pass on the second attempt will mean that the placement is failed. A failed placement has significant implications for future enrolment.

6. Written expression is to be clear and succinct, without grammatical or spelling mistakes.

7. Terminology is to be correctly employed; without the use of non-psychological jargon.

8. There is to be a clear link between the presenting symptoms, formulation, diagnosis, evidence base, and treatment plan.

9. It is not necessary to present a very complex case in order to demonstrate your assessment skills. Choose a case that best highlights your thinking about a case and how you managed to integrate the psychological data to formulate a diagnosis (if relevant) and/or treatment plan.

Case Report Format

It is recommended that the following structure of headings and content are observed for the case reports.

Sessions with Client

- Date first seen
- Number of sessions
- Period of treatment (e.g., 8 months)

Referral Section

- Reason for referral
- Referral source (may be self-referred)
- Background to the referral
- Context (agency, setting)
- Include a summary of all pertinent information; like an abstract or synopsis

Client Presentation

- Assessment of client based on Mental Status Examination – e.g., mood, affect, cognition, behaviour or organisational issues

Presenting Problem

- Client's presenting problem; description of problem(s), including:
  - All symptoms relevant to the diagnosis, described so that they 'match up' with the proposed diagnosis
  - All symptoms relevant to establishing the differential diagnosis; and
    - *Symptoms, Severity, Frequency*
    - *Time frame for symptoms*
    - *Triggers, Onset, Duration, Intensity & Course*
    - *What the client has tried to address the problem*
    - *Impact*

- This section is to include your assessment of client and presenting issues and demonstrate that you have also assessed relevant problems/symptoms in order to delineate the specific diagnosis from other potential diagnoses Also include information pertaining to strengths (not just problems); as this will help delineate the problem and inform as to diagnosis
- Assessment of risk and risk factors may form part of this section or may be better located at the end of the 'Relevant Background History' section, which follows.

Relevant Background History

- Family
- Educational
- Psychosocial
- Medical/psychiatric history or client and family (if relevant)
- Alcohol/drug (alternative this can be included in the Presenting Problem section)
- Offending (if relevant)

- Previous treatment intervention and response (if not included in the *Presenting Problem section* above)

Test Administration – i.e., Psychometric assessment section

- Rationale for test selection must be clearly outlined - any tests must be selected, used and interpreted appropriately;
- Brief interpretation of results using correct terminology
- Results must be appropriately integrated into assessment and diagnosis.

DO NOT INTRODUCE ANY NEW INFORMATION AFTER THIS SECTION.

Case Formulation / Case Conceptualisation

- Clearly identify and integrate the five Ps:
  - Presenting problem (only brief sentence required, given more detailed summary presented earlier)
  - Predisposing factors that make the client vulnerable to the presenting problem;
  - Precipitating factors that are associated with the onset of the problem;
  - Perpetuating factors that help to maintain the problem; and
  - Protective factors: Strengths or supports that are likely to facilitate response to intervention.

DO NOT INTRODUCE ANY NEW SYMPTOMS THAT WERE NOT INCLUDED IN THE 'PRESENTING PROBLEM' SECTION

Diagnosis

- Use the DSM-5 to provide a diagnosis, if relevant (if no diagnosis is given, explain what may have been considered but why the client did not meet diagnostic criteria).
- If a diagnosis has been made by another professional, evaluate the diagnosis in the context of the client's current presentation.

Rationale for Diagnosis

- All criteria are fully evaluated and justified against presenting symptoms.
- Differential diagnoses are considered, and rationale provided for exclusion.

DO NOT INTRODUCE ANY NEW INFORMATION OR SYMPTOMS (OR LACK OF SYMPTOMS) THAT YOU HAVE NOT SPECIFIED IN THE CLIENT PRESENTATION, PRESENTING PROBLEM OR BACKGROUND Sections.

Discussion of Evidence Based Theories

Discuss relevant evidence-based theories and models (e.g., CBT) and how these inform diagnosis, formulation, and treatment plan and intervention delivery.

Intervention Plans

The plan must be realistic, given complexity of issues, number of sessions available and experience of the therapist.
If doing an '*assessment case*' study:

- Suggest possible courses of future evidence-based interventions and plans

If doing an '*intervention case'* study:

- Describe and clearly link intervention plans with the diagnosis/ formulation
- Clearly identify treatment goals and targets and specific intervention strategies for achieving these (the 'what' and how' of the plan)
- These must be clearly linked with diagnosis, formulation and evidence-based theories
- Plan for managing risk factors, if indicated

Intervention Delivery

Delivery must be consistent with plan and demonstrate intervention skills. It must clearly link intervention strategies and approaches to the issues specified in the assessment section and the evidence-based theories. Include:

- A succinct summary of the intervention process (not a session by session account)
- Examples of how the intervention was implemented
- Demonstrate intervention skills in implementing the plan; evidence of on-going monitoring of effectiveness of intervention; and evaluate the outcome of the intervention.

Reflection

- An overview of how the effectiveness of the intervention was evaluated, including details of any changes in presenting symptoms/behaviour.
- A reflection of what has been learned professionally and how your practice may be modified in future to improve outcomes.

Case Report Checklist (for students use)

***Note**: The case report is intended to be a real-life depiction of a client you are currently working with at your placement. The aim of a case report is to demonstrate a thorough knowledge of how to approach a psychological assessment, apply diagnostic criteria from the DSM-V and plan interventions.*

Students name:

Section A: Format information & Reason for Referral

- Case is deidentified ☐
- Reason for referral is clearly specified ☐
- Case Report structure follows the recommended format ☐
- Written expression is clear, accurate and succinct ☐

Section B: Psychological Assessment Section

- Client Presentation: Appropriate observations based on MSE ☐
- Presenting Problem & Symptoms ☐
    a) All symptoms relevant to the diagnosis are identified ☐
    b) All symptoms relevant to establishing differential are identified ☐
    c) Subtle distinguishing differential diagnostic factors are addressed ☐
    d) Refers to TRIGGERS, ONSET, DURATION, INTENSITY, COURSE, IMPACT ☐
- Risk assessment ☐
- Background information & relevant client history ☐

Section C: Psychometric Testing Section (if applicable)

- Brief rationale for test selection ☐
- Appropriate application of test and interpretation of results ☐
- Results are meaningfully integrated with the overall assessment ☐

Section D: Case Formulation Section

- Case formulation/ Case conceptualization (Use 5 Ps) ☐
    a. Integrates vulnerabilities, triggering events, and maintaining factors
    b. Integrates Presenting, Predisposing, Precipitating, Perpetuating, & Protective factors ☐
    c. Client strengths and supports are identified ☐

Section E: Diagnosis Section

- Provides comprehensive 'Rationale for Diagnosis' (where a diagnosis is made) ☐
- List all the criteria met and not met ☐
- Provides rationale for 'Differential Diagnoses' ☐

Section F: Evidence-Based Theory

- Discusses relevant evidence-based theories and models and how this guides assessment, diagnosis, and especially treatment planning and intervention delivery ☐

Section G: Intervention Plans

- Plans are clearly linked to the assessment and the evidence-based theory ☐
- Plans address systemic issues as well as psychopathology ☐

Section H: Intervention Delivery (where applicable)

- Intervention is consistent with plan ☐
- Cleary links intervention strategies / approaches to the issues specified in the assessment section and to the evidenced-based theories. ☐

Section I: Future modifications & Self-Reflection

- Discusses future modification in the light of an evaluation of outcomes & reflection on own practice. ☐