Transforming Research Methods in the Social Sciences

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Section Two

Qualitative methods
The central place of case study research in psychology

The systematic observation and study of individual cases is, claims Bromley (1986, p. ix), the ‘bedrock of scientific investigation’. However, when we look at courses on research methodology in psychology, where case study research often does not feature, or is treated as very much a second-class citizen, we might be forgiven for thinking that Bromley was exaggerating. In this chapter I show that Bromley was right. Meaningful knowledge has to be built on, and relate to, observations of specific phenomena in the world. This means that the study of cases is the foundation. Historically, we see this in the work of Charles Darwin (1809–1882), who was fascinated by the observations of natural phenomena from everyday life made by ‘naturalists, explorers, colonial administrators, missionaries and others with whom he corresponded all over the world’ (Sheldrake, 2004, p. 4). The careful study of cases has long been the foundation of medical science and practice. In 1769, Giovanni Morgagni, for example, described over 700 clinical cases in which he could link clinical symptoms to autopsy findings (Eells, 2007).

Case study research can play an important role in all branches of social science (Baxter & Jack, 2008; Bromley, 1986; Hancock & Algozzine, 2011; Yin, 2014) and readers wanting guidance in applications not covered here are encouraged to consult these sources. However, most of the points examined in this chapter have broad relevance to any case study research. This chapter focuses on case-based evaluation of therapy,1 and a case refers to the assessment and therapy process of an individual who has sought help for psychological problems. There is already a rich trove of these going back to the nineteenth century (Ellenberger, 1970). Andries Hoek, a Dutch medical doctor, describes the successful treatment in 1851 of a woman with multiple psychological traumas, using a hypnotic uncovering method. This case study provides evidence that sophisticated forms of psychotherapy were being practised before Sigmund Freud was born, in 1856 (or Pierre Janet in 1859). Van der Hart and Van der Velden (1987, p. 266), who examine the case, observe that ‘Hoek was probably not aware of the theoretical and therapeutic importance of the uncovering approach he reported’. Freud’s case studies
are famous for being beautifully written (Billig, 1999) and, although his conclusions on specific issues have been regularly disputed by critics, his accounts present enough clinical detail to allow for meaningful discussion from different theoretical perspectives. In the extended case study of ‘Miss Beauchamp’, in a 500-page book, Prince (1906) offered rich clinical detail of dissociative processes in personality and how these can be addressed in therapy. A personal account by another of Prince’s patients of her successful treatment for ‘dissociated personality’ was published in two articles in the Journal of Abnormal Psychology, of which Prince was the founding editor (Anonymous, 1908a, 1908b).

It seems only natural to base clinical practice on a science built on the careful observation of cases. As Flyvbjerg (2006, p. 222) puts it, ‘Context-dependent knowledge and experience are at the very heart of expert activity. Such knowledge and expertise also lie at the centre of the case study as a research and teaching method.’ Yet half a century after Freud’s and Prince’s case studies, this kind of attention to cases had been dismissed as unscientific within the social sciences, with the exception of anthropology (Mitchell, 1983). One reason for this was concern about whether clinicians’ case descriptions and the conclusions they drew from them could be regarded as trustworthy. Readers have to take the author’s claims at face value and often have no way of checking whether the account of the case was accurate or the interpretations well grounded. As Spence (1986, p. 211) points out, the author may succumb to ‘narrative smoothing’ and simplify and distort what really happened in a way that is misleading but makes a good story.

What is scientific knowledge? A clash of epistemological paradigms

As shall be seen, there are ways of addressing these concerns about trustworthiness, but a more significant reason for the marginalisation of case studies was a conflict between paradigms with respect to the definition of scientific knowledge (Edwards, Dattilio & Bromley, 2004). Based on the successes of nineteenth-century physics, psychologists sought to establish their own science on similarly respectable foundations. This meant measuring and quantifying variables and finding mathematical relationships between them that would provide general laws. This approach to building knowledge is epistemologically different from that of what Glaser and Strauss (1967) would later call building grounded theory. Two prominent psychologists pointed this out in the 1930s. Lewin (1931) drew attention to the difference between Aristotle’s approach to knowledge founded on a search for general laws, and that of Galileo whose focus was on specific concrete observations, from which all theory needed to be derived and needed to be able to account. Similarly, Allport (1937) made the classic distinction between idiographic research that examines the specifics of individual cases, and a nomothetic approach that looks for general laws or principles. More recently, Miller (2015) pointed to Toulmin’s (2003) distinction between scientific rationality, which is based on the search for certainty with respect to general laws, and
human reasonableness, which can pragmatically address ‘local problems that may never appear again in the same form’ (Miller, 2015, p. 51).

Nomothetic researchers dominated the social sciences in the second half of the twentieth century. They believed that there could be only one kind of scientific knowledge, so they dismissed qualitative case studies out of hand as the knowledge they provided seemed incompatible with what they believed to be science. The strengths, even the centrality, of the case study for science, cannot be appreciated within the nomothetic perspective (Flyvbjerg, 2006). Yet, in clinical and counselling psychology, the findings of nomothetic research are of limited value in offering guidance on how to deal with the details of individual cases. Consequently, for decades, many practitioners ignored the research literature as irrelevant (Dattilio, Edwards & Fishman, 2010; Edwards, 1998). Unfortunately, nomothetic researchers also ignored the last stage of the research process – communicating findings to the people who can act on them. Traditional research reviews have little impact on practitioners even if they actually read them. But practitioners can relate to and draw from a case study (Stewart & Chambless, 2010). My own practice was significantly influenced by case studies I read, such as those of Bugental (1965, 1967) and Lazarus (1985).

Fortunately, with the resurgence of qualitative research in the last decades of the twentieth century, there has been a greater appreciation of the importance of the idiographic approach to knowledge development. Even in qualitative research though, the idiographic emphasis may be lost because, in looking for common themes across several participants (e.g. in typical applications of qualitative analysis), researchers easily lose touch with the complexities of the individual lives of those who took part (McLeod & Elliott, 2011). In case study research this can be avoided by making the individual case ‘the unit of interest and the unit of analysis’ (Eells, 2007, p. 35). Although case study researchers are also interested in commonalities and differences between cases, cross-case comparisons are always a second step in the research process, after the complexities of individual cases have been closely examined.

Proponents of mixed methods research argue that the epistemological conflict between idiographic and nomothetic paradigms can be resolved by recognising the complementarity of the two kinds of knowledge. Both approaches can be combined within a single study in which not only are qualitative and quantitative methods used together, but the kind of knowledge each generates is used alongside the other as a means of correcting the distortions or limitations inherent in a single approach (Johnson & Onwuegbuzie, 2004; Johnson, Onwuegbuzie & Turner, 2007).

A particularly promising application of this would be the conduct of case studies within therapy trials (Fishman, Messer, Edwards & Dattilio, 2017). In such studies, a randomised controlled trial (RCT) would evaluate the efficacy of one or more approaches to therapy, then detailed case studies of participants in the trial would be written, typically of at least two cases: one that responded well to treatment and one that responded poorly or was a treatment failure. For examples of this, after the RCT was published, see Burckell and McMain (2011),
Goldman, Watson and Greenberg (2011) and Watson, Goldman and Greenberg (2007, 2011). However, in a truly mixed methods study, it would not be enough to publish the findings of the RCT and of the case studies separately. The main publication would need to synthesise the insights gained from both kinds of analysis. This is done in several chapters of Fishman et al. (2017).

Conducting a systematic case study

The many forms of case study research include what are often called single-case experimental designs where the main focus is on quantified variables and their patterning across time (Barker, Pistrang & Elliott, 2015; McLeod, 2010). However, this chapter focuses on the systematic case study, also called the pragmatic case study (Fishman, 2013; McLeod, 2010; McLeod & Elliott, 2011), in which a qualitative case narrative is a central part of the report. This is a comprehensive approach that provides a rigorous way of investigating therapy interventions and, as shall be seen, safeguards can be built in that enhance the trustworthiness of any conclusions drawn. There are five basic steps: assessment; case formulation; intervention planning; contracting; and implementation and evaluation of impact.

Assessment phase

In the first step, the assessment, the practitioner gathers information to gain a thorough understanding of the case and to determine whether a psychological intervention is appropriate. Although some therapy approaches do not use a formal assessment, there are dangers to this. For example, a client with what may seem like stress headaches may actually need a brain scan, not counselling. Or consider the case of Sally (Miller, 2015) who, though previously a good student, was having difficulty concentrating on her work. The counsellor guided her to work behaviourally to increase her self-discipline, but this had no impact. Only in passing, at the end of session three, did Sally mention her father’s recent death. In session four, in response to further questioning, Sally revealed that he had committed suicide and she was the one who had found him dead. He had been depressed since her mother’s death several months before as a result of lifelong alcoholism. In this case, what looked like an academic problem was in fact a case of unresolved traumatic grief.

Edwards and Young (2013) present a systematic approach to assessment that would protect clinicians from launching into an intervention prematurely, as happened in Sally’s case. Such an assessment is itself a research process and provides a sound basis for a systematic case study. The clinician should choose some self-report rating scales that can be completed by the client on a regular basis as a way of tracking progress (Young & Edwards, 2013). There are two broad types of scale, symptom and process (McLeod, 2010). Symptom scales measure specific problematic symptoms associated with the client’s distress, such as depression or anxiety, or, more specifically, anxiety associated with traumatic flashbacks or worrying, or social avoidance.
Process measures tap aspects of the way clients relate to the therapist and the therapy approach. The therapeutic alliance is a particularly salient process factor as it has a big impact on the progress of therapy (Norcross, 2011). The alliance refers to a combination of three factors: the extent to which therapist and client agree on the goals of therapy; the extent to which they agree on the tasks of therapy, which might lead to reaching the goals; and the overall quality of the bond between them. Many measures of the alliance are available (Horvath, Del Re, Fluckiger & Symonds, 2011), including the Working Alliance Inventory (WAI) and the Agnew Relationship Measure (Stiles et al., 2002; see Hill et al., 2011, for a case study in which the WAI was used). Alliance ruptures impact negatively on the course of therapy and by tracking and identifying them, clinicians can safeguard the process of the therapy (Safran, Muran & Ewbanks-Carter, 2011). Indeed, the processes involved in an alliance rupture and its subsequent repair may be of particular interest in a case study (Rabu, Halvorsen & Haavind, 2011). Other measures of process could include such factors as the client’s motivation and readiness to change (Prochaska & Norcross, 2001) and the credibility to the client of the therapy approach.

The use of such scales incorporates quantification into the case study and the use of standardised scales allows for comparison with other cases. In this respect, the systematic case study is a mixed methods approach. However, from an idio- graphic perspective, scales used in case studies do not need to be standardised. Researchers can devise their own scales that measure the particular features of the case they are interested in (Bilsbury & Richman, 2002; Elliott et al., 2015; Hill, Chui & Baumann, 2013).

Case formulation, treatment planning and contracting phases
The assessment provides the basis for the second step, the development of a case formulation, a basic step in most approaches to psychotherapy (Eells, 2006). This embodies a set of clinical hypotheses about the factors that led to the development of the client’s difficulties and their perpetuation in the present. In Sally’s case, for example, the clinical hypothesis would be that her concentration difficulties were caused by her attention being distracted by thoughts and emotions related to her unresolved traumatic grief.

This is the basis for the third step – making an intervention plan. Interventions are selected that are likely to address the client’s difficulties and bring about change, if the clinical hypotheses in the case formulation are accurate. The choice of interventions is based on evidence from the literature about how interventions work and what is indicated for what kind of problem. For Sally’s case, the disruptive effects of traumatic grief on everyday functioning, and the value of guiding clients to face the painful feelings evoked and deal with the mourning process, are well documented (Ehlers, 2006; Prigerson et al., 1997). With a well-founded formulation and treatment plan, the individual case offers an opportunity to examine the clinical theory and practice that has been developed for that particular kind of problem. For a case study in which traumatic grief was part of the problem, see Karpelowsky and Edwards (2005).
The fourth step is to make a contract with the client about the implementation of the intervention. This may be a fairly informal process in which the therapist explains what has been learnt from the assessment, how s/he understands the client’s problems and their causes (the formulation), and how the planned intervention might be expected to be helpful. There are four reasons why this step is important. First, as a consumer of services, the client has the right to know what the therapist is offering and on what basis it is offered. Second, it provides a foundation for the therapeutic alliance which is based on a shared understanding of the goals of therapy and the means by which those goals will be worked towards (Horvath et al., 2011). Third, clients are likely to be more motivated to engage with the therapy process when they understand the rationale for it. Fourth, for a research project, it is important that research participants give informed consent to whatever procedures and processes they are asked to engage in (McCleod, 2010).

**Intervention phase**

In the intervention phase, the plan is implemented and the processes that take place are tracked. Therapy interventions are always unique because therapists behave responsively to their clients (Edwards, 2010; Van der Linde & Edwards, 2013). How the client responds to suggestions or information or empathic or interpretive remarks will in turn affect the therapist’s behaviour (Kramer & Stiles, 2015). So as the therapy unfolds, whether over a few sessions or many, it will be a process with its own distinctive features. The best way to capture the detail is for the sessions to be recorded, at least on audio. In much psychotherapy research, video recordings are routinely used as these capture additional dimensions of the data (e.g. Hill et al., 2011). Having access to recordings enhances the trustworthiness of the research process, especially when transcripts are included in the case narrative. Carl Rogers (1942) was a pioneer here: in his account of the case of Herbert Bryan, he broke new ground by including transcripts that illustrated the principles of client-centred therapy (Edwards, 1998).

It is also important to ensure that the therapy approach remains faithful to the case formulation. This can be done by the clinician reflecting on each session and having supervision with someone who understands the treatment model. Of course, new information can come to light that may change the case formulation and therefore the therapist’s approach, and this is itself an element of the responsiveness that is part of psychotherapy.

During this phase, some or all of the self-report scales used in the assessment phase should be given to the client on a regular basis. Such scales are useful clinically, in that they alert clinicians to whether progress is being made and allow them to address problems that are flagged when the scales show that the client is not getting better or is not engaged in the therapy process or does not have an alliance with the therapist. When clinicians respond to such information, it enhances the effectiveness of the therapy (Lambert & Shimokawa, 2011). For research purposes, such scales provide additional data about the client’s experience and contribute towards evaluating whether the client received meaningful help.
Data collection
The data collected during these phases include session recordings, notes made by the clinician during or after each session, information provided by the client (who may, for example, be asked to write down a brief life history, record thoughts and feelings in challenging situations between sessions, or keep a journal), and responses to the self-report scales. In some cases, during the assessment collateral information might be collected from family members. For the case study, all this is research data, the raw material from which the case study will be constructed. It is also recommended that research interviews are conducted with the client about his/her experience of the therapy and about the positive and negative aspects of the experience after therapy is completed, and even after every few sessions. This can be done by an independent interviewer using a structured interview such as the Client Change Interview Protocol (Elliott, n.d. a) or Helpful Aspects of Therapy Form (Elliott, n.d. b).

Data condensation
Data condensation methods are used to reduce a large body of data to manageable proportions (Miles, Huberman & Saldaña, 2014). One form of data condensation is the scoring of the self-report scales and displaying the scores at different times on a graph. Two important qualitative data condensations are an organised summary of the assessment data and the case formulation and treatment plan. Although these are clinical steps, they are also research steps and remind us that much of what working clinicians do involves skills that are the same as qualitative research skills. The case formulation and treatment plan are more than data condensations, though. They are interpretive steps wherein clinical theory is applied to the assessment data to derive an approach to treatment. However, a sound case formulation is never speculative but must be thoroughly grounded in the information available, both the explicit information about the client, and the implicit information gained from observing the client’s responses and psychological states as the assessment proceeds.

The most challenging data condensation is the case narrative, which is an account of the therapy process based on the session recordings. To prepare for this, some or all of the recordings are transcribed (McLeod, 2010, discusses just how much is needed). The material must then be shortened to fit in with the requirements of the medium in which it is to be presented: thesis, book chapter or journal article. The narrative will be selective in that the researcher will select sessions or sections of sessions that are salient and omit those that are of little or no relevance. What is relevant, however, is determined by the second feature of the narrative – that it is thematic. Writing a case narrative is always an interpretive step which, as in much qualitative research, draws on central themes that emerge from the interpretive questions that the researcher wants to answer and from further reflection on the case material. These themes and questions become lenses through which researchers look back on the case material and draw out answers to the questions that concern them. In constructing the narrative, we need to describe the processes of relevance to our questions because this is what provides evidence for the conclusions we will later draw.
An important characteristic of the case narrative is that it is a particular way of communicating to readers aspects that cannot be conveyed in other forms of research writing. A well-written narrative can take readers into the therapy room and engages them existentially and emotionally with what took place there. It should therefore be written in ‘a way that allows the reader to enter into the lived experience of the therapy’ (McLeod, 2010, p. 103). This means writing ‘thick descriptions that include the detail, complexity, context, subjectivity, and multifaceted nature’ (Fishman, 2013, p. 406) of the experiences being presented; that can engage readers in a manner that is ‘compelling’; and that ‘discloses, transforms and inspires’ (Finlay, 2011, p. 26). For examples, see Edwards (2013), Padmanabhanunni and Edwards (2015), Payne and Edwards (2009) and Van der Linde and Edwards (2013).

Ethical aspects of clinical case study research

Because clinical case study research involves publication (e.g. in a thesis or journal article) of material that discloses sensitive information about an individual’s life and experience, particular ethical concerns arise. First, researchers must attend to participants’ privacy. Clients’ attitudes to privacy can range from not being willing for any of the material to be used under any circumstances, to feeling something like ‘if my experience can help others, then I am happy for it to be put out there’. To address privacy concerns, identifying information can be reduced by using pseudonyms for all people mentioned in the narrative; giving broad rather than specific information about such things as the client’s home town or profession or the profession of family members; giving inaccurate information that does not impact on the psychological aspects of the study (e.g. we might write, ‘Melissa’s family lived in another province, and her father, an engineer, travelled frequently on projects’, where Melissa is a pseudonym, her family lived in another city in the same province and her father was an architect).

Second, participants need to feel that their experience has been fairly represented. This is easy where there is a good working alliance, and therapist and client have worked collaboratively and share an understanding of the problems being addressed, the goals of therapy, and how the therapy is contributing towards reaching those goals. Where therapist and client are at odds and do not have a shared understanding of these factors, the participant may well feel aggrieved by the way the case is presented. To address these concerns, participants can be thought of as co-investigators engaged in a ‘co-operative inquiry’ (Reason, 2003) and invited to read and comment on the case study. A carefully worded informed consent procedure can be designed to address these issues and could include requesting consent at different points in the research process, and even having a third party obtain the consent to protect the participant from feeling pressured by a need to please the therapist. For a thorough discussion, see McLeod (2010) and Miller (2004).

Third are concerns arising from the dual role when, as typically happens, the author of the case study is also the therapist. Given the huge contribution to
science of case studies written by practitioners (reviewed earlier), it is important not to see this as a reason for practitioners not to write case studies. The dual role has advantages: the therapist has engaged deeply with the participant’s experience and will do so further in writing the case study. Such deep engagement is central to good phenomenological research, and the therapist’s deepened understanding may benefit the client. However, there is the concern that in writing the narrative, therapists will select and distort information in ways that fit in with their theoretical or ideological perspectives. This is an aspect of the concern about the trustworthiness of arguments and conclusions; ways to address this are examined more broadly in the next section.

**Drawing conclusions and enhancing trustworthiness**

Qualitative researchers are always concerned about ‘standards of quality and verification’ (Creswell, 1998, p. 193). Lincoln and Guba (1985) use the term ‘trustworthiness’ of findings, which they break down into credibility, transferability, dependability and confirmability. Credibility refers to claims about causality. For example, if the author claims that the therapy helped the client, the credibility of this would depend on the quality of the evidence presented in the case study as well as the consideration of competing explanations. Transferability refers to how useful the findings might be in a different context. For example, would findings from how therapy does or does not work in an inner-city clinic in America be of interest or relevance to a clinic in a South African township? It also refers to the extent to which findings can inform meaningful action. For example, might the behaviour of therapists who read the case study be altered in a helpful direction? Dependability means that ‘the process through which findings are derived should be explicit and repeatable as much as possible’ (Morrow, 2005, p. 252), which means an audit trail should be available that adequately describes the process. Confirmability refers to whether independent readers of the study would come to the same conclusions on the basis of the evidence presented.

Trustworthiness is about how well founded and socially meaningful the conclusions are. An oft-repeated criticism of case study research is that we cannot generalise from any one case. This displays an ignorance of how knowledge is built in qualitative research based on a grounded theory/hermeneutic approach. Generalisation takes place by reading the details of the case in light of existing knowledge and theory. We interpret one case and learn from it based on what happened with other cases or what the literature says, based on experience with similar cases or related phenomena. So we can often draw conclusions or at least advance strong hypotheses from single case studies. But these need to be argued for from the data. In quantitative multivariate research, there is a formal testing of hypotheses using statistical methods. In qualitative research, by contrast, conclusions are drawn through ‘analytic generalization’ (Yin, 2014, p. 40) or ‘abduction’ (Haig, 2008, p. 1021), which means using the evidence of the data
and a chain of argument. This is the kind of reasoning clinicians use (Vertue & Haig, 2008).

There are many ways to enhance the trustworthiness of qualitative research in general (Kvale & Brinkman, 2009; Morrow, 2005; Shenton, 2004) and of case studies in particular (McCleod, 2010; McCleod & Elliott, 2011). Strategies for strengthening conclusions that include testing and ruling out alternative explanations are extensively described in the qualitative research literature (Miles et al., 2014; Taylor & Bogdan, 2016) and are elaborated by Bromley (1986) and Yin (2014) in relation to case study research. Elliott’s (2002) hermeneutic, single-case efficacy design is a structured approach to establishing trustworthiness in relation to the question of whether the therapy helped the client. Elliott summarises the kinds of evidence to document and shows how two sets of arguments can be written out, for the claim and against it. Independent judges are then asked to review these and comment and adjudicate (Elliott et al., 2009; MacLeod, Elliott & Rogers, 2012; Stephen, Elliott & Macleod, 2011).

Not all cases are worth turning into case studies. We usually only write up those from which some worthwhile conclusions can be drawn. But with their rich contextual information, cases lend themselves to many different kinds of conclusion, which may not just be about the effectiveness of the therapy method. Case studies of treatment failures, for example, allow us to look at when a therapy approach is not appropriate or needs to be modified (Fishman et al., 2017; see Rizvi, 2011, for an example). In a series of case studies, Edwards and his students examined the effectiveness in South Africa of a cognitive therapy treatment model for posttraumatic stress disorder (PTSD). Some of these were treatment failures (Padmanabhanunni & Edwards, 2012, 2013b, 2016), but the case data provided a basis for important reflections and conclusions about treating clients who have limited resources. Others provided evidence for treatment effectiveness (e.g. Boulind & Edwards, 2008; Padmanabhanunni & Edwards, 2013a, 2014, 2015), but each case brought into focus the challenges of the particular contexts and traumatic events facing each client.

Although most of these case studies were planned, case studies can be written retrospectively from therapies that are complete, provided there are sufficient data (McLeod, 2010). Raby and Edwards (2011), for example, retrospectively wrote up the case of Paul, a boy who was successfully treated (by Raby) in a few sessions following years of unsuccessful treatment by a range of health professionals. There was an extensive documentation of the history of Paul’s presenting problems and of the previous failed treatments, as well as of the treatment process, even though no recordings were made. One aim of the study was to understand why the correct treatment had not been offered previously, and another was to look at the implications for children’s rights within a public healthcare setting of the way Paul and his family had been dealt with by some of the health professionals involved.

Whatever the conclusions the author of a case study wants to argue for, they will be strengthened by many aspects of the systematic case study method presented above: the use of recordings; the process of case formulation based on a thorough assessment and a well-grounded clinical theory and incorporating
explicit clinical hypotheses; the use of repeated self-report measures; and the use of research interviews. For the case narrative, an independent judge can be employed to read the transcripts and the narrative and comment on whether there are omissions or distortions that mean that the narrative is not a fair presentation of what happened.

Concluding remarks and suggestions

Although case study research can be technically complex and challenging, it is very worthwhile to document and examine closely the processes that occur within therapy cases. Readers who want to write case studies are encouraged to read some of the case studies cited above. Many South African case studies are included and there are others to draw on (Drake & Edwards, 2012; Edwards, 2013; Edwards & Bailey, 1991; Edwards, Henwood & Kannan, 2003; Edwards & Kannan, 2006; Leibowitz-Levy, 2005; Mashalaba & Edwards, 2005; McDermott, 2005; Whitefield-Alexander & Edwards, 2009). Padmanabhanunni’s (2010) PhD thesis, based on seven South African case studies of the treatment of PTSD, is available online, and many of the present author’s case studies can be accessed from his ResearchGate page.²

Internationally, the journal Clinical Case Studies publishes case studies that follow a structure similar to that recommended in this chapter. There are set headings that include the research basis for treatment, the presenting problems and case history, diagnostic assessment, case conceptualisation, course of treatment and complicating factors, treatment implications and recommendations to other clinicians. The journal Pragmatic Case Studies in Psychotherapy is free online.³ Most issues of the journal include case studies with commentary by experts that addresses methodological as well as clinical concerns. Some issues are entirely devoted to case study research methodology. A special issue of the journal Counselling and Psychotherapy Research, introduced by McLeod and Elliott (2011), includes several case study articles. A free online source of psychological case studies has just been launched by the University of Essex in the United Kingdom,⁴ and it is likely that the number of studies available will expand considerably over the next few years.

Finally, it is recommended that case studies in the literature are read with a critical eye, bearing in mind the discussion about trustworthiness and the process of establishing a well-founded argument. Not all published case studies do well when measured against these criteria.

Notes

1 For convenience, the term ‘therapy’ will be used to refer to any counselling or psychotherapy interventions.
2 https://www.researchgate.net/profile/David_Edwards16/publications
3 http://pcsp.libraries.rutgers.edu/index.php/pcsp
4 http://singlecasearchive.com/about
References


Systematic case study research in clinical and counselling psychology


