How to Conduct and Write a Case Study in an Easy Way: Guidelines for Psychotherapists in Practice

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Abstract

Case studies represent a methodology suitable for practice-oriented research. In this article, case studies are introduced as a natural way of gaining knowledge, within which psychotherapists can use skills which are a natural part of their psychotherapy practice. Basic steps in conducting a case study are explained in the article: (1) Determination (Why we do a case study?); (2) Preparation (What we want to know?); (3) Data collection (What could a minimalistic version look like?); (4) Analysing and writing down (The usual structure of an empirical study). The article introduces case studies as a meaningful and enriching way of integrating research into psychotherapy training and professional development of psychotherapists in practice.

Key Words: case study, psychotherapy research, practice-oriented research, research methodology

Introduction

Case study has a long tradition in psychotherapy. It is a natural way of creating and imparting knowledge about how psychotherapy works. It often speaks to us in much more convincing terms than extensive studies and meta-analysis. Unlike those methods, it does not take the case out of its original context, but captures it in a network of relationships and influences that contributed to its formation. It does not tell us what the average effectiveness of each approach is, yet it gives us a much better understanding of what specific changes the client underwent and which processes most likely led to them.

For example, a typical randomized efficacy study may show that clients who have undergone therapy achieved (on average) a change the size of $d = 0.80$ in the overall distress rate, and that 8% (again on average) of this change can be explained by the quality of the working alliance between the client and the therapist (or other variable targeted by the study). On the other hand, a case study can show us the areas in which the change occurred, the concrete manifestations of these changes in the client's life, and also the areas where the therapy was not successful.

Above all, however, the case study will help us understand the importance the observed change has for the client himself. Due to a detailed understanding of the case context, we can also conclude whether a particular key moment or aspect of the therapeutic process contributed to the change (e.g. the moment when the therapist admitted his mistake or helped the client to see his trouble from a new perspective) or a change of external circumstances (e.g. a change of a job position). The persuasiveness of a case study therefore lies not in the “brute force” of generalizing statistics, but in the sensitivity to the nuances and specificity of the given case.

In our article, we focus on so-called systematic case studies. It is not just a case-by-case narrative from the therapist's point of view, but an independent genre of empirical study. It is characteristic that the researcher (who may or may not be the same person as the psychotherapist) asks a clearly formulated question that they want to answer in their study, and collects and integrates different types of data for that purpose.

Such an idea may seem somewhat detached from common clinical practice, but on closer inspection we find that this is not the case. Every psychotherapist asks questions in their practice (Was this therapy successful? Which of my interventions was most useful? What processes of change took place during therapy? How the client experienced and evaluated the therapy? How they integrated profits from therapy into their daily life?). In an effort to get an answer to them the psychotherapist seeks the information they need and acts, either intentionally or intuitively, as a "professional scientist". That is why science cannot be defined only as a set of certain "scientific" procedures but as an attitude that includes disciplined questioning, critical thinking, imagination, rigour, scepticism, and openness to change in the face of evidence (Stricker, 2002). Such a scientific attitude is not inconsistent with common practice, but rather the opposite - it is the attitude of a responsible practitioner who tries to reflect and further develop their work.

A case study can serve many different purposes, whether documenting and evaluating a new therapeutic approach, developing psychotherapeutic theory, analysing some critical

moments or aspects of practice, or using a case study for training purposes (McLeod, 2010). However, irrespective of which of these objectives we pursue, general principles and procedures can be formulated to guide the creation of a good case study. In the following text we describe the basic steps in conducting a case study so that it can be carried out by a psychotherapist in practice. We also include tables offering links to additional sources for readers who want to learn more about the topic.

Table 1: For Further Reading

For those interested in a deeper understanding of case studies in psychotherapy and counselling, we especially recommend the book *Case Study Research* (McLeod, 2010). If the reader is looking for a broader ideological background that would serve as a manifesto for a case-based approach to research in psychology and psychotherapy, he may refer to *The Case for Pragmatic Psychology* (Fishman, 1999).

Stage 1: Determination

Determination is like the fuel we take before traveling. There is continuously less and less fuel, so it is important that we have enough fuel at the start. At the beginning, if we want to make a case study, we need to ask honestly and with a natural interest, why a case study? What is it good for? What sense is there in spending a lot of hours of research work on this particular type of project?

A case study is a research methodology suitable for practice-oriented research. This type of research is currently an influential and growing trend that responds to the still insufficient bridging of the gap between academic research and common psychotherapeutic practice. A case study seems ideal for such purposes. It is a “smaller bite”, a comprehensive research project of a smaller scope, for which there is no larger institutional and grant support needed. A good case study can be conceived as an interesting side project along with psychotherapeutic practice or study. It can also be developed by an individual, or a small team, which may consist of only a therapist and a researcher (e.g. a student writing a thesis).

However, it is good to admit right at the outset that even such a project requires a great deal of time and effort. What can work on such a project give us in return? The crucial aspect of a case study is that it represents a research methodology close to practice. The results are concrete and easy to understand. In addition, it offers the psychotherapist feedback and inspiration for his daily work. In this sense, research can help not only the professional development of a psychotherapist, but it can also be an important moment in preventing

burnout that threatens a practitioner who is in routine practice with many clients. Engaging in a research project allows the psychotherapist to focus his attention on a different place than usual, noticing changes more carefully and systematically, changes that they would otherwise overlook as being normal and expected. This alone can, not only help restore a sense of meaningfulness to your own work, but also bring unexpected satisfaction in rediscovering how many forms psychotherapeutic practice has and how complex and essentially adventurous it is. The psychotherapist can learn to view their own work from a different perspective. This can stimulate a revival in their creativity and renew motivation for meaningful studies of new theoretical and research findings that develop psychotherapy as a subject.

It is surprising how many psychotherapists after some time in routine practice have a desire to "do" research but do not know how to do it simply and economically. Case studies offer a well-manageable opportunity to combine practice with research, and maybe even enrich our education with a doctorate. For students interested in psychotherapy, a case study represents the possibility of a thesis research project from which they can learn something for their practice. Furthermore, participants in psychotherapeutic training, who write a casuistic thesis at the end of the course, can use a case study research methodology to add an extra dimension to their work and even prepare it for publishing.

Stage 2: Preparation

The determination that motivates us to decide to work on a case study also affects the wording of the *research questions*. These are the questions we ask at the beginning and we look for their answers in our research. Such questions then direct our interest in a particular direction that then determines how our research project evolves. For example, we may want to learn something about our practice and ask ourselves: “How much does therapy help my clients? And how specifically does it actually do so?” The research question may initially be similarly nonspecific, and later, when we have already gathered some data or if we get interested in a particular aspect of therapy, we can narrow it down.

This research question example focuses on two important areas of psychotherapy research: the magnitude of change and its explanation. If we want to explore these two areas, we need to start thinking about what tools to use. We can choose from a number of tools, so here we summarize what types of tools are available and give specific examples.

To determine whether *a case was successful* (i.e. whether there was a desired therapeutic change), we need to have evidence of the changes that clients have achieved in

therapy. It is useful to keep in mind from the start that change can be both quantitative (something gets smaller or larger) and qualitative (something is different) at the same time. Accordingly, we will choose the tools to help capture the change. Both perspectives, quantitative and qualitative, have some advantages and disadvantages. A case study offers a place for their meaningful combination, which builds on exploiting the strengths of both perspectives.

We need to rely on standardized questionnaires to see *how big was the change* in the clients' problems, and at the same time to assess *what significance* the change has. The available questionnaires focus on different kinds of problems, so already in choosing we have to decide on our specific interests. Some questionnaires measure the *general level of distress* and are useful when we want to find out how clients are doing overall and whether their problems or quality of life generally improve during psychotherapy. These include the CORE-OM, ORS, or OQ-45 questionnaires. These tools are described in more detail in Table 2. However, we may also be interested in whether some *specific problems*, such as anxiety symptoms or depression, are changing. In that case, we choose from tools that measure specific symptomatology, such as PHQ-9, or capture a wide range of problems, such as SCL-90. These tools are described in Table 3.

Table 2: Example of Tools for Measuring General Symptomatology and Functioning in Society, Work and Relationships[1]

CORE-OM (Clinical Outcomes in Routine Evaluation - Outcome Measure). The CORE-OM questionnaire is a 34-item questionnaire that measures frequently-occurring problems and classifies them into four areas: personal well-being, social functioning, symptoms and the level of risk to yourself and others. The printed version is available free of charge in Czech translation and it has also been published as a psychometric evaluation (Juhová et al., 2018). There are also shorter versions of the questionnaire consisting of 18, 10 and 5 items. The questionnaire is suitable for assessing the overall level of problems and quality of life of clients. At the same time, it allows the capture of the risks, occurrence of which should not escape attention during psychotherapy (e.g. suicidal thoughts or violence).

[1] Some of the questionnaires mentioned in the tables here are also synoptically listed on the website of the Center for Psychotherapy Research (Department of Psychology, Faculty of Social Science, Masaryk University in Brno): https://psychotherapyresearch.fss.muni.cz/nabizime/vyzkumne-nastroje. A number of tools have been translated into Czech, so those interested can contact the authors of the study if they are interested in using one of the tools.

OQ-45 (Outcome Questionnaire 45). The OQ-45 questionnaire is another example of a tool that measures the most commonly encountered problems and is therefore suitable for monitoring overall client change during therapy. It organises problems into three groups: symptoms, difficulties in interpersonal relationships, and difficulties in functioning in a social role. It has a total of 45 items, so it is longer than CORE-OM. However, shortened versions with 30 or 10 items are also available. The OQ-45 currently appears to be the most empirically researched instrument focused on general problems. It does not have an official Czech translation and psychometric validation yet, however the Slovak version is available (Bieščad & Timuľák, 2014). Use is charged.
WHO-5 (World Health Organization Wellbeing Index). The WHO-5 questionnaire is designed to measure overall life wellbeing. It uses only five items for this purpose and is therefore suitable for use in everyday therapeutic practice and for repeated assignment to clients. Compared to the previous tools, it does not assess clients' problems, but their contentment, thus emphasizing strengths rather than weaknesses. Use of this tool is free, there is a Czech translation, and the tool has adequate psychometric properties (Topp et al., 2015).
ORS (Outcome Rating Scale). The ORS questionnaire (Duncan et al., 2003) measures overall client wellbeing with the use of only four items, making it suitable for regular assessing and capturing sudden fluctuations in client's problems. It focuses on three dimensions (personal, interpersonal relationships and wider social functioning), while asking about overall wellbeing. Given the shortness of the questionnaire, its administration can be a part of the session, including a discussion over the results. The ORS questionnaire is available in Czech and its use is free for individuals after registration with the questionnaire provider (only applies to the paper version), but the Czech version has not yet been validated.

Table 3: Example of Instruments for Measuring Specific Psychopathology

PHQ-9 (Patient Health Questionnaire-9). The PHQ-9 has nine items that focus on diagnosing common depression symptoms. It was originally designed to recognize depression in patients in medical care. However, its simple administration, length, free use and good psychometric properties make it a tool suitable for use in routine psychotherapeutic practice for regular detection of depression symptoms. The instrument was translated into Czech and its psychometric properties were validated (Daňsová et al., 2016).
GAD-7 (Generalized Anxiety Disorder-7). The questionnaire is very similar to the PHQ-9 but focuses on measuring anxiety symptoms. It has only 7 items, so it is suitable for regular measuring of client's anxiety problems. It is also free to use, has a Czech translation and good psychometric properties (Spitzer et al., 2006).

SCL-90 (Symptom Checklist-90). Using 90 items, the SCL-90 measures the symptoms of mental illness in nine areas: phobic anxiety, anxiety, depression, hostility, interpersonal sensitivity, psychoticism, paranoia, obsession and somatization. It turned out that the individual areas overlap quite a lot, so only the overall severity index calculated from all items is often used. Nevertheless, individual dimensions can provide a more detailed view of specific client issues. The instrument has a Czech version and good psychometric properties (Bieščad & Szeliga, 2006).

Aside from trying to determine the severity of symptoms and problems, it may also be important to discover the extent to which the problems affect the clients' lives: how clients manage to function in society, at work and in interpersonal relationships. This evaluation is contained in some instruments measuring general levels of distress (e.g. CORE-OM, OQ-45) as well as instruments measuring specific symptoms (e.g. PHQ-9, GAD-7).

People come to psychotherapy with various problems, so the quantity of methods available is beneficial. The questionnaires also have some limitations. Making a case study we can handle this thanks to relying on more data and perspectives.

One of the disadvantages associated with measuring therapeutic change using standardized questionnaires is that we evaluate only those problems that occur most frequently (that is why they are included in these questionnaires). For example, it may be a sense of hopelessness, which is captured by most of the questionnaires measuring the general level of distress. However, it may happen for instance, that the client considers a feeling of inner confusion as their most significant problem. We would therefore like to measure how this experience diminishes (or increases) during therapy. Instruments that measure general distress or specific symptoms may not recognize such a specific change.

In such a case, we can use tools that measure problems formulated by clients (e.g. PQ, which we describe in Table 4). Compared to standardized tools in which clients answer a list of pre-prepared items (problems), these tools create items for each client in a new and unique way. Together with clients, we always create a list of problems at the outset and then, during therapy, clients assess to what extent they are still being disturbed by their specific problems.

Such tools are particularly useful for use in making case studies, as they make it possible to measure changes that clients themselves consider important. Some of them also solve another problem in standardized questionnaires: clients' understanding of individual items in the questionnaire may change during psychotherapy. Nevertheless, if clients create the items themselves, we can ask them if they began to understand them differently during psychotherapy than they did initially. The disadvantage of these tools is the time investment

associated with their creation at the start of a therapy session (creating a questionnaire can easily occupy the entire session) and the difficulty of comparing the recorded changes with the data received from other people. On the other hand, if they are used together with standardized questionnaires, we can exploit the benefits of both approaches.

Table 4: An Example of a Tool that Captures Client Formulated Problems

PQ (Personal Questionnaire). The PQ questionnaire is used to measure client problems during therapy. The difference from other questionnaires focusing on client problems is that PQ has items specific to each client (Elliott et al., 1999). The rules and forms of creating this questionnaire have been translated into Czech and, according to foreign studies, have good psychometric properties (Elliott et al., 2016). This tool usually has 8 to 12 items that clients can create either prior to the start of psychotherapy with researchers, or the creation of items at the first session with a psychotherapist can be used to map clients' problems.

In addition to capturing the extent of change through questionnaires, a *qualitative understanding* of how clients perceive change during psychotherapy can also be helpful. For example, it may happen that standardized questionnaires may not show any significant improvement in symptoms. Nonetheless, when we ask clients about changes in their symptoms, we find that they understand their problems after therapy better or look at them from a different perspective that is more beneficial to them (Roubal et al., 2018). For instance, physically experienced anxiety, which they initially perceived as an obstacle to effective functioning, may begin to be understood as an important signal to warn them of overwork. Thus, although the intensity of the symptom is not improving (therapy is unsuccessful in this aspect), the client perceives a fundamental and useful advance (which he achieved through therapy).

A qualitative examination of change is possible, for example, using the retrospective interviews (CHAP, CCI) described in Table 5. We can also use them with therapists to compare whether and how their understanding of change achieved in therapy differs from the perspective of clients. Systematic written records may also serve the same purpose. Therapists record what changes they observe during therapy and how they can name them. This may also be the most natural way of collecting data for most psychotherapists, as they use it routinely in their practice and it does not require additional time investment from them. On the other hand, while qualitative assessment of change brings rich and unique data, it requires more

time-consuming data collection and analysis than using questionnaires. This must be anticipated in advance.

Table 5: Examples of Tools Capturing Change Retrospectively

CCI (Client Change Interview). The semi-structured CCI interview is intended to qualitatively and numerically capture a change in psychotherapy from the perspective of clients. Individual groups of questions focus on the following areas: changes for better or worse since the beginning of psychotherapy; evaluation of changes in terms of their expectancy, probability of occurrence even without psychotherapy and significance; perceived causes of changes in psychotherapy and non-psychotherapy related causes; client resources and limits related to changes; and helpful and inhibiting aspects of psychotherapy (Elliott & Rodgers, 2008). The tool can be used during or only at the end of psychotherapy and provides a detailed insight into how clients perceive the change they made and its causes. The interview is available in the Czech version.
CHAP (Change After Psychotherapy) represents a semi-structured interview after the psychotherapy, through which we capture changes as the client experiences them in various areas of their life. Furthermore, it allows to identify from the client's point of view what contributed to the change in therapy (e.g. used techniques, therapeutic relationship, extra-therapeutic factors). It uses the natural flow of conversation similar to a therapeutic session, while offering guidance to explain the nature of change. The method also includes quantitative scales assessing the extent to which the clients consider themselves as changed (in terms of symptoms, adaptive capacity, insight and basic conflict) and how they relate it to various aspects of the therapy. Special training is needed to evaluate the quantitative part, but it is possible to use the qualitative part alone. The method was originally based on a psychoanalytic theoretical frame (Sandell, 2015), but it can also be adapted for other approaches. A translation of the manual is available in Czech and its publishing is planned.
Q-PC (Questionnaire of Personal Changes) is a twelve-item questionnaire, which is administered after the end of therapy. The client retrospectively assesses how big a change, whether positive or negative, they experienced during the period while they were receiving therapy (Krampen, 2010). The questionnaire has an official Czech translation, but we do not have its psychometric validation and Czech standards yet.

Another possible way of examining the therapeutic process is by trying to explain *how the change in psychotherapy occurred*. We are looking for what has caused the recorded change, and we are looking for evidence of events or properties of therapy that may have led to clients' improvement. Here we first need to find out what changed. That is why we compare the default and the resulting level of client problems (e.g. using CORE-OM, ORS or PQ questionnaires). We can also measure the change several times during psychotherapy, not

only at the beginning and at the end. This gives us more detailed information about the development of the problem and during therapy, we have an idea whether it helps the clients[2]. We then try to link the detected changes that the clients achieved during therapy with what happened and how it occurred during psychotherapy. We can understand the causes of change in psychotherapy by using tools to capture the various factors associated with the change. We then connect these with the clients' improvement expressed numerically, qualitatively, or both.

One of such crucial factors is, for example, the working alliance. Its quality can be measured using SRS or WAI questionnaires (see Table 6) and then correlated with achieved changes. If changes seem not to be achieved for some clients, then we can specifically focus on whether non-improvement or deterioration is related to the overall quality of the working alliance (i.e. whether the rating of the alliance is unusually low). If we regularly assign such questionnaires on the work alliance during psychotherapy, they will also help us identify specific sessions where the quality of the alliance has deteriorated or improved. Besides the working alliance, we can also measure other therapeutic factors associated with change (e.g. SACiP). The same procedure will then allow us to explain, through these factors, the change that occurred and to identify the sessions that need to be examined in more detail.

Table 6: Examples of Tools for Capturing the Therapeutic Process

WAI (Working Alliance Inventory). The WAI questionnaire measures the quality of a working alliance with 36 items, and there is also a shorter version with 12 items (Munder et al., 2009). The questionnaire is useful both for the occasional and, in the shorter version, for more frequent measurements of three factors of the working alliance: agreement on the therapy goals, ways of achieving them, and emotional relationship between clients and therapists. Although this apparently most used questionnaire for working alliance measurement has been translated into Czech, there are still many tests of psychometric properties in English, that are missing in Czech.
SRS (Session Rating Scale)**.** The SRS Questionnaire is a short questionnaire suitable for regular use during therapy to monitor quality of the working alliance. Like the ORS questionnaire, it uses only four scales to graphically measure the three components of a working alliance (agreement on goals, ways to achieve goals, and the emotional relationship between clients and therapists) and its overall quality. Psychometric properties were validated on foreign samples and found satisfactory (Janse et

[2] The exact opposite can also happen and clients' problems get worse. In addition to data collection, the tools used can help us recognize and understand such development. This seems particularly useful since most therapists have difficulty recognizing deterioration in their clients (Hatfield et al., 2010).

al., 2014), the Czech translation of the instrument is available and its use is subject to the same conditions as the ORS questionnaire.
SACiP (Scale for the Multiperspective Assessment of General Change Mechanisms in Psychotherapy). The SACiP questionnaire has 21 items that focus on general mechanisms of change in individual psychotherapy. It has a version for capturing the perspective of both clients and therapists. It includes six areas: the emotional bond between clients and therapists; problem update; activation of resources; clarification of meaning; consensus on how to cooperate; and the feeling of coping. The questionnaire has been translated into Czech, its Czech validation has not yet been made, but the original foreign study shows satisfactory psychometric properties (Mander et al., 2013).

Previous tools have helped us link the change to some of the causes, or also identify the sessions which require more attention. However, they did not show us how clients perceive the relation between what happened in psychotherapy and its outcome. To do this, we can use client change interviews that include questions about what clients think contributed (or not) to change in therapy or in their non-therapy life (for example, the CCI, CHAP tools mentioned above). Or we can, with clients who agree to it, watch the recordings of selected sessions and talk to them about what helped them in these sessions. This can be done, for example, by IPR interviews. The same procedure can be used with psychotherapists. With them we watch recordings of selected sessions and ask, how they see the change and its causes. Subsequently, we can compare the view of psychotherapists with that of clients. A detailed analysis of the session is, however, very time consuming and also requires cooperation with colleagues who will conduct such an interview with the client or therapist. A simpler way to capture the causes of change from the therapist's point of view is again to use the therapist's notes.

We can also try to explain the change by asking clients and therapists, either after each session or after some sessions, which moments they perceived to be particularly helpful or burdening (e.g. the HAT or IPR tools described in Table 7). These moments can then be linked to the psychotherapy outcome.

Table 7: Example of Tools Focused on Significant Moments Identified by Clients and Therapists

IPR. The semi-structured IPR interview serves to explore the experiences and thoughts that respondents had during moments captured on an audio or video record (Elliott, 1986). It can be used

along with the recordings of psychotherapy sessions to explore what clients and therapists have thought and experienced throughout the session, or during moments chosen by clients, therapists, or researchers themselves. These interviews can be particularly useful to gain insight into the processes of the change that are taking place during a session. The interview is available in Czech in a specific version, which focuses on experiencing, thinking, and physical experience of respondents during important events in the session.
HAT. On one A4 form, the HAT questionnaire asks clients what were the most important events that took place during the session that just finished (Elliott, 1993), whether the events were helpful or hindering, and what they took from them. This questionnaire can be useful for regularly monitoring the most important events during therapeutic sessions, which is not as time consuming as using semi-structured interviews.

In case studies, research questions formulated to explore what change in psychotherapy occurred and how we can explain it are probably the most common. However, we can also be interested in the other questions. For example, we may want to find out *whether the theory of our therapeutic approach corresponds to reality* or *how we can develop the existing theory*. In that case, we will gather evidence of events and processes that confirm and refute the particular theory.

Theories usually aim to predict what will happen and under what circumstances. In order to verify the theory, we try to capture, with the aid of various methods in a case study, whether some interventions or events have the expected consequences. If, surprisingly, there were other consequences that we would systematically pursue in a larger number of case studies, we would gradually accumulate evidence to develop the original theory. In obtaining evidence confirming or refuting the theory of the particular approach, we would once again use the perspective of a therapist, researchers, colleagues, or clients, which would provide us with stronger evidence to confirm or develop the theory.

So how do we choose which case to conduct? We have two basic choices: either we choose the cases for which we subsequently collect data in advance, or we already have data from several cases at our disposal and choose which to focus on and examine in more detail.

With the first option, we select the case based on theoretical criteria and research literature. We choose a case that shows something important to complement our understanding of psychotherapy. For example, we can select a case where the consequences of using motivational interviews with clients with both mental and addiction problems are shown (Carey et al., 2007).

The second option means to be surprised and select a case based on what we find in data collection and analysis (see Table 8 for guidelines). Only when we examine the selected case do we find out how we can theoretically understand it and how our understanding can be linked to the existing theoretical knowledge.

Table 8: Data-Based Case Selection

If we select the case only on the basis of knowledge of data, we can be captivated by its various properties. McLeod (2010) defines five basic criteria for case selection: a) typical case - a typical or representative case within a population b) extreme case - case showing selected phenomenon in an extreme form c) deviant case - a case that has developed in an unexpected way d) influential case - a case that has previously attracted much attention e) innovative case - involves the use of a new or innovative form of therapy

Phase 3: Data Collection

The tools described above can be combined to enable us to answer the research question we ask in our case study. The combination of tools may depend on a number of conditions, such as the availability and difficulty of using the tools, the main focus of a workplace, or the personal interest of a therapist. Since a frequent obstacle to practical research is the fear of it being time demanding and difficult, in Table 9 we will describe the four undemanding options by which the tools can be combined if we want to explore some important topics. The fact that these variations are so undemanding can serve as an inspiration for practice-oriented research that uses collaboration between psychotherapists and researchers.

If we choose some undemanding method of creating a case study, the data collection may not take much time. However, we have to take into account the need to provide practical things, such as submitting questionnaires (e.g. who will submit questionnaires and when, and how will clients receive instructions for filling them in) or planning interviews (who, where, when, how long and with whom the interviews will be conducted).

It is also necessary to ensure and think through the storage, anonymization and data archiving. For example, if we record all sessions, we gradually accumulate a large number of large data files that we need to store somewhere and protect against being damaged or accessed by others. Likewise with the questionnaires, we have to ensure anonymity of participants, archiving, and often also transferring data to electronic form. Before you start

collecting data, you need to print out questionnaires and interview charts in advance, or prepare a recording device. There should be more than one in case one of the devices fails.

We must also have pre-prepared information on research for clients and have their informed consent, without which we would not be able to collect and process data and publish such work. Informed consent must contain a description of everything we would do with the data, so we must make sure that the formulation is correct so that a situation where we cannot use the data for some originally intended purposes cannot happen. For instance, we must have consent to recording, consent to collection and storage of questionnaires, consent to the use of data in published works, and consent to those who will have access to the data. We should also provide a contact to the research guarantor to whom the participants may direct eventual questions.

Table 9: Examples of Easy Data Collection and Tool Combinations

Option I: Overall Change
To determine if and to what extent psychotherapy helped clients, we give them a standardized questionnaire measuring general discomfort (CORE-OM) and one questionnaire measuring specific problems (e.g. PHQ-9 with a client with depressive problems, GAD-7 with a client with anxiety problems) at the beginning and the end of therapy. Using these questionnaires, we will be able to calculate whether the change is clinically and statistically reliable (see Table 10) and we can, for example, based on recordings of psychotherapist sessions and detailed records, chronologically describe the development of therapy, used interventions, and their impact on the client from the therapists', researchers' or even the clients' point of view. The advantage of this way of data collection is that it is undemanding, it allows for a comparison with the rate of change with other clients or with larger groups of people. The disadvantage is that as therapists we never know which session is the last (clients can decide at any time to stop the therapy), so we may not be able to compare the initial and final level of the client's problems.

Option II: Continuous Development of Change

If we wanted to continuously record improvements in the basic areas of our clients' lives, we could give them a short change questionnaire (one of the shortest is ORS) before each session. At the same time, with the help of a similarly short SRS questionnaire, we can ascertain how good the working alliance between a psychotherapist and a client is after each session. The working alliance is linked with the change and can help explain low or fluctuating changes in the problem. The advantages of this data collection procedure are once again the fact that it is not time demanding and, moreover, it continuously captures the development of clients' problems and provides feedback on each session. Since the therapist can discuss possible deviations directly with the clients using completed questionnaires, the questionnaires can enhance receiving feedback on the course of therapy. The disadvantage of this way of data collection may be that it is necessary to think about assigning tools continuously and it may also take time before the therapist (often more than clients) gets used to the regular use of questionnaires.

Option III. Evaluation of Change Retrospectively

Another cost-effective combination of methods resulting in a systematic case study relies on retrospective questioning. After a psychotherapy that caught our interest, we can ask clients to provide a retrospective interview about the change (such as CHAP) or to fill in a questionnaire (such as Q-PC), which records the rate of change achieved throughout the whole psychotherapy. By analysing the obtained data, we can then determine in what way and how the therapy helped. We can use notes from sessions to supplement information about the course of therapy. The advantage of retrospective data collection is that we can wait until the end of psychotherapy to select a topic to focus on. However, we will never have the pre-psychotherapy status, which is important for assessing whether the change perceived by clients or psychotherapists is affected by limited memory or the participants' efforts to ingratiate themselves with the therapist by giving them positive assessment.

Option IV: Therapy Recording

A time-saving option, but much more dependent on trust between clients and therapists as well as data handling (storage, security, backup), is the recording of all sessions on a Dictaphone or camera. The advantages of recording are the relatively undemanding organisation of the data collection, which becomes routine with time, and getting extensive data that can be handled in a variety of ways. Recording of all sessions can also be useful as we assign additional tools and need to look at something that we found interesting during specific sessions. Nevertheless, the disadvantages include the relatively time-consuming processing of the recordings (for example, transcribing only one psychotherapy session of 50 minutes takes about 6 hours), and also the shyness or potential impact of concerns about being recorded on the psychotherapy process.

Similarly, undemanding options of data collection can give the therapists useful information in practice and contribute to the development of psychotherapy theory when used systematically. At the same time, it is possible and advantageous to combine these four basic variants of data collection or add other tools to them. For example, we can combine session recordings with interviews about clients' change at the end of psychotherapy and see what the interventions and situations that clients identified as being associated with an achieved change looked like. If we have room to do so, we can add questionnaires collecting information about the change in symptoms. This will allow us to support the claim that the change with the clients has really occurred and also to show how big it was.

It is useful to try to think about combining different methods in advance, so that it does not become overwhelming. Combining methods enables us to capture and convey at least partially the great complexity of psychotherapy in an understandable form to the readers. Case studies are particularly suitable for this.

Phase 3: Processing and Writing

The advantage of a case study for a practitioner is that he or she usually does not need to know special methods for basic data processing. The basic approach is to critically examine and systematically compare data from different sources. We are trying to find what answer the data offer us, given by the research question we asked at the beginning of our research project. However, there are also various special methods (qualitative and quantitative) that can be used in collaboration with the researcher (see Table 10).

Table 10: What special methods can be used for data analysis?

The basic processing of a case study usually does not require knowledge of special methods. However, their use can significantly enrich the analysis. If we work with continuous quantitative capture of a change, it is sufficient to plot the values in graph and assess them visually. For a more precise assessment of a change, we can use the concept of clinically significant and statistically reliable change. (Jacobson and Truax, 1991). In addition the Studies that monitor one or more process variables can use simple correlation analysis to capture the relationship between a therapy process and its outcome (Elliott, 2002). For the processing of session transcripts or subsequent conversations with a client or a therapist, we can use any of the methods of qualitative analysis (see, e.g. Řiháček, Cermak and Hytych, 2013), such as a thematic analysis, Grounded Theory method or any of the phenomenological approaches. It is also possible to focus on detailed analysis of

conversation between a client and a therapist, where appropriate methods can be the conversation analysis or discourse analysis.

Finally, what remains is to write the study so that it can be published in a professional journal. This step still requires the last bit of determination, yet it is a very substantial phase that crowns the whole long-lasting effort. Publishing our case study represents more than just a reward for research work. We make our work available to colleagues who can get inspiration from it and also provide us with feedback. In addition to that, in general we contribute to the growing knowledge in the field of psychotherapy, which moves the whole field forward and allows better use of practice in empirical research. Case studies may serve as a lead to more general conclusions (see Table 11).

Table 11: Can more general findings be acquired from case studies?

A case study captures an individual case which is in its uniqueness unrepeatable. Nevertheless, under certain conditions we can deduce tentative conclusions or hypotheses from a case study. For instance, if there is a recurring pattern in a case (some intervention repeatedly leads to improvement, a certain situation in therapy repeatedly appears to be an obstacle, etc.), it can be assumed that clients with similar characteristics or in similar situations will follow this pattern as well. This hypothesis can then be verified by carrying out further case studies. More general knowledge is based on aggregation or meta-synthesis of several case studies (Iwakabe and Gazzola, 2009), and that is via similar replication logic as applied in group designs (Hilligard, 1993) or on the principles of building grounded theory (Glaser and Strauss, 1967) or the principles of qualitative meta-analysis (Timuľák, 2013). An important step in this endeavour is the creation of large case study databases, where the largest is probably Single Case Archive (Desmet et al., 2013).

When writing an article, we follow the usual structure of an empirical study, which consists of four basic parts: Introduction, Method, Results, Discussion. In the Introduction we present a basic problem (focus of the study) and the theoretical background that forms the framework of our study. In the Method, we introduce the reader to the case and its context, and describe the tools and methods we used to obtain and process the data. The objective is to allow readers to assess generalizability (based on similarities or differences from other clients) and enable reproducibility of the entire research process. In the Results we present and integrate information from different perspectives. For example, we can compare the results of various questionnaires with the client's experience and the observations made by the therapist. We return to the research question and focus on what different options for

answering data processing offers. In the last part of the article, the Discussion, we try to explain our results, compare them with the basic theory described in the Introduction as well as with the results of other similar studies.

Before writing the final version of the article, it pays to verify the requirements of the journal in which we want to publish our article. The usual experience of beginning writers is to write a text that is too long, and later shortening is painful and laborious. Capturing a case in a short format with a given structure will force us to highlight the main findings we made in our case. Different journals may have their requirements related to a specific form of case study the journal focuses on. In this article, we describe common basic principles of case studies, however there are also their special formats that can serve as an inspiration and which are suitable for various purposes (see Table 12).

Table 12: Special case study formats

Pragmatic Case Study (Fishman, 1999, 2005) offers a basic framework for capturing and documenting the course of therapy under normal practice circumstances. It leads researchers and therapists to reflect on the theoretical concept on which their work is based, to capture the initial and continuously modified case formulation, therapeutic interventions, and to evaluate their effect.
Hermeneutic Single Case Efficacy Design Study (Elliott, 2002) provides a comprehensive instructions on targeted collection and integration of information from different sources (continuous measurement of change, therapeutic process variables, records of therapeutic sessions, retrospective statements of client and therapist, etc.). Now, it is usually being combined with the "jury research" method (Bohart et al., 2011; Stephen and Elliott, 2011).
Theory-Building Case Study (Stiles, 2007) focuses on confronting some existing theory with the reality of a particular case and aims to further develop this theory.
N-of-1 Trial (Herrera et al., 2018; Rizvi and Nock, 2008) understands therapeutic intervention as experimental manipulation and examines its impact on case development.
Narrative Case Study (McLeod, 2010) aims to qualitatively capture meanings and experience associated with psychotherapy. For instance, it can obtain information from clients' journals, interviews, session recordings or other products of the process.

Conclusion

Let us make a few final recommendations. Focus on what attracts your interest and what makes sense to you. There is no study that could cover everything, it must inevitably narrow the research down. Concentrating our curiosity on the direction shown by the research question will make us content.

When choosing research methods, it should be borne in mind that each method has its benefits and limitations. For that reason, it is advantageous to combine methods. At the same time, however, we need to estimate our strength realistically, therefore we are offering minimalist variants of data collection here.

Conducting a case study can be challenging, so it is useful to work with other colleagues. An example could be a situation where a practicing psychotherapist comes up with an idea for some research and where data could be collected, and an academic at a university helps to find a methodological solution. The practitioner can then collect data and a student carries out a thorough analysis as a part of their thesis. As a result, the practitioner receives research-based feedback on their work.

A promising area for the application of research case studies is psychotherapeutic training. Many training courses are completed by writing a case report. The training participants can work in pairs. One of the two works with a client therapeutically, the other conducts and processes a retrospective interview with the client (and perhaps also with the therapist). The therapist thus again receives research-based feedback and their final case report gets enriched with complex reflection. It is also possible to involve a supervisor who can help with theoretical framing and interpretation of the findings. The resulting article can be a work of a joint effort. In summary, case studies are a relatively simple research tool that is meaningfully linked to practice and offers psychotherapists possibilities for professional development.

Note

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