

SECTION 9: CASE REPORT GUIDELINES

PART 1: GENERAL INFORMATION ABOUT CASE REPORTS

AIMS, FORMATS AND BREADTH OF CONTENT

Aims

The work clinical psychologists undertake is underpinned by their ability to apply models and theories, used in a reflective and an iterative way. Most clinical work can be seen as a process – assessment leads to hypotheses about how best to intervene, and monitoring the way the intervention unfolds gives feedback about how well these hypotheses fit the clinical picture. A sense of openness to this feedback and a capacity to reflect on one’s own practice (often through supervision) is also central. All of this represents clinical competence, and case reports are a chance for you to demonstrate this and your development as a clinician. As such, the course uses them as one of the indicators of your capacity to function as a Chartered Clinical Psychologist.

Overall they give us a chance to look at:

- a) your developing clinical competence across a range of different types of work and setting, in the context of a range of theoretical perspectives
- b) your ability to integrate academic and theoretical ideas with your clinical experience
- c) your ability to reflect on the way in which clinical, professional and ethical issues interact and impact on your work

Formats

You need to complete a total of four case reports (as well as one service-related research report, which is described in Section 20).

There are two compulsory formats:

- 1) The first case report (submitted at the start of the second term of the first year) must be a report of an assessment.
- 2) The second report must be based on a transcript (taken from a tape-recording), using the actual clinical material to reflect on therapy process.

For the remaining two case reports you can choose from the formats in the table below. Each format may be used only once. The table should make this clearer:

possible formats for case report	a single-case study
	an “advanced” assessment report
	a theory-oriented report
	a report of a completed clinical intervention
	a report of an impasse in a psychological intervention

The criteria for these case reports are described in more detail in Part 2.

SCHEDULE OF SUBMISSION

The table shows the overall plan. The service-related report should be submitted as the third or fourth report.

		Type of report
Year 1	Two reports submitted	Case report: compulsory format - report of an assessment
		Case report: compulsory format – transcript-based report
Year 2	Two reports submitted	Usually the Service-Related Research report, but a case report can be substituted
		Case report (choice of formats) or the Service-Related Research report
Year 3	One report submitted	Case report (choice of format)

Submission dates can be found on the web. See Section 24 for further details on handing in work.

Breadth of content

By the end of the Course you will have a “portfolio” of 5 reports. The aim is for this to cover a reasonable range of clients, contexts and interventions – the idea is to demonstrate some progression in your thinking and the development of a broad repertoire of skills applied in a variety of settings. None of this would be very apparent if, for example, all your case reports described treating a person with an anxiety disorder using CBT.

As far as is possible you should aim for a portfolio which covers as broad a range of clients, contexts and types of intervention as possible. There may be limits to this, especially because the first three reports have to be based on the work that is available to you in the first 12 months of the Course. Nonetheless, it is a good idea to think ahead and to try to plan for as great a diversity of reports as your placement experience permits.

It is always a good idea to discuss the appropriateness of cases with your Course Tutor before you start writing the report.

Defining “breadth” is best done in relation to the BPS Accreditation criteria (a schematic diagram showing these can be found at the end of this document). It’s worth remembering that one case can cover quite a few of these factors at once, though as above, your choices may sometimes be limited. If in any doubt, talk this over with your Course Tutor.

a) A range of cases drawn from across the lifespan:

This is defined as at least:

- one case of work with a child (under 16)
- one case with an adult (between 20 and 55)
- one case with a person in later adulthood (aged 55+)

These age-bands indicate the spread of ages required, and are not intended to be interpreted rigidly. The important point is that you should try to choose cases that can show your competence in working with individuals across the life-span.

b) A range of severity and chronicity of presentation:

The meaning of terms such as severity and chronicity may vary across different client contexts, but ideally the portfolio of cases should describe individuals with a range of presenting problems – from acute onset through to serious and enduring presentations.

If possible at least one report should present a psychological (as opposed to a psychotherapeutic) intervention with an individual who has difficulty in expressing their needs verbally (for example, because of their level of psychological disturbance, because of neurological problems such as severe dementia or brain injury, or because of intellectual disability). Usually these cases will focus on individuals with high levels of support needs, often in the context of social marginalisation.

c) A range of psychological approaches:

You should be able to demonstrate competence in more than one model of formal psychotherapy. Bear in mind that in this context “model” is a reference to broad approaches - cognitive-behavioural, psychodynamic, systemic, humanistic, or integrationist. On this basis, breadth would not be represented by variations on cognitive approaches, or by Kleinian as contrasted to Freudian modes of psychodynamic therapy.

d) A range of settings:

As far as possible the portfolio of reports should cover work carried out in different contexts – in the BPS criteria these are defined:

- i) in relation to different levels of the healthcare system (primary care, secondary or tertiary/specialist), and
- ii) in relation to the intensity of treatment and the likely dependency level of the client - whether patients are treated as outpatients, in more intensive settings (for example a day-unit), or in residential settings (such as an in-patient setting, residential homes or a therapeutic community).

Obviously the number of reports limits the number of settings you can cover, but you should aim for a range, and try to ensure that at least one report describes work undertaken in the context of inter-professional working (e.g. where the case involved direct or indirect work with another professional or with members of a multi-disciplinary team).

In summary, the “portfolio” of reports should ideally include:

cases drawn from across the lifespan
variation in severity and chronicity of presentation
variation in psychological approaches
variation in settings
at least one report demonstrating inter-professional working

PRESENTATION OF REPORTS

Basic formatting

Reports should be:

- Typed
- Double-spaced
- Stapled
- Each page must be numbered

The cover sheet should give the following information:

- Title of report
- Type of case report (e.g. “assessment report”, “theory-oriented reported” (etc))
- Number of report and date of submission (e.g. Case Report 1, January 2012)
- Your course code number (this is given to you by administrative staff)
- The word count (see below)
- A formal statement regarding confidentiality, as follows:
 “all names used in the report have been changed in order to preserve confidentiality”
- A statement indicating whether or not client consent was sought/ obtained for the report

All citations and references should be in APA format. (**there is a guide to APA style at the end of this document.**)

Your supervisor also needs to submit a separate sheet indicating that they have seen the report and that it is a fair representation of your work (the form is available at www.ucl.ac.uk/clinical-psychology/docs/SupervisorCaseReportConfirmation.doc).

Length of reports

The maximum word count for case reports is 3000 words¹. This excludes references and appendices. This is an absolute limit, which cannot be exceeded.

The only exception to this word limit is where a transcript from a taped session is included; guidance on this point is given in the description of the “transcript based therapy process report”.

Quality of writing, grammar and spelling

Case reports are submitted as part of the thesis. As doctoral level reports they should be clear, with few spelling or grammatical errors, or errors introduced as a result of word-processing. You are strongly recommended to use the spell and grammar-checking facilities offered by your computer, and to read through your reports *before* they are submitted.

Up to a point, content is the main focus. However, you will be required to revise reports that contain a large number of grammatical or spelling errors. If a trainee appears to have serious difficulties with their writing, the course expects them to acknowledge this and to work with their tutor on a plan to identify the actions needed to remedy this. This could include attendance at one of the writing courses offered by UCL (details at www.ucl.ac.uk/calt/acp/acwri.htm; also online help with grammar and other resources at www.ucl.ac.uk/calt/acp/stu.htm).

Preserving copies of case reports for binding into the dissertation

The reports will be marked internally as you submit them. On the basis of feedback some reports may need to be revised. The final version of the five reports (four case reports and the service related research report) will be bound together, and will form part of the thesis you submit in the third year.

You are responsible for keeping copies of your reports in such a way that they can be submitted at the end of training. Losing copies of your reports would cause you major problems (and a lot of extra work).

For this reason it is critical that you retain a secure electronic copy of the final version of the report (electronic rather than hard copy because you will need to convert the reports into thesis format,

¹ The maximum word count for the Service-Related Report is 4,000 words

and hence revise markings and page numbers). Whatever format you use (e.g. disc or memory stick), some basic security tips are worth following – we strongly advise keeping copies on more than one disc or memory stick in case of hardware failure, theft or loss.

CHOOSING A CASE

Understandably, trainees often imagine that the Course is looking for reports of “successful” cases. In fact we are looking for the ability to make links between theory and practice, to reflect on the work and to show appreciation of any issues raised by the clinical material. Whether the case has a “good” outcome is much less relevant than your ability to demonstrate a thoughtful and sensitive approach to practice. Although it is always nice to read about successful outcomes, the report is not a test of your ability to make things better.

You do not need to restrict yourself to work that has been completed; unfinished work can be just as interesting and useful. Clearly there is a balance here: it may not be sensible to submit a report based on a very limited amount of clinical contact.

Case reports do not need to be based on “complex” cases, or ones that are especially “interesting”. Routine casework is fine, and in reality pretty much any clinical case could be written-up. Sometimes trainees avoid writing up straightforward cases because they fear they aren’t “interesting” enough; bear in mind that even straightforward cases can be difficult to write up, and complex cases very challenging!

We very strongly recommend that before you start writing you talk to your course tutor about the cases you have in mind.

Reporting joint work

You may submit a report on work that you have undertaken jointly, but the report should always make clear which aspects of the work were your own responsibility. This includes work which you have carried out with your supervisor, although the write-up should be your own. If you are on placement with another trainee, you could submit a report on work you have done together (e.g. running a group, or teaching to a team, etc.), but this is only appropriate if each report focuses on a separate, defined piece of the work and cross-references the existence of other report.

SUPERVISION AND SUPPORT FOR WRITING THE REPORT

Involving your course tutor

You are strongly encouraged to discuss your ideas about the case report with your course tutor before you start writing. Tutors can help you think about which of your current cases seem most appropriate for a report, and which format is best suited to the write-up.

Tutors cannot look at a draft of the report (because all reports are blind marked, they could be marking it). However, they can discuss the proposed structure of the report; this is often extremely helpful in helping trainees to think both about focus and content.

Involving your clinical supervisor

It is a good idea to discuss your plans for a case report with your clinical supervisor, since s/he will be familiar with the cases you are working on. However, bear in mind that although your supervisor's opinion is useful, the case report is your work. This means that your report may not (and does not need to) include all the areas discussed with your supervisor.

You should show your supervisor a final version of your report; they need to sign and return to college a standard letter confirming that you undertook the clinical work you describe (available on

the web). Bear in mind that the supervisor is not being asked to judge the quality of the work, only to confirm that it reflects the work you carried out.

MAINTAINING CONFIDENTIALITY

Reports will only be read by course staff and external examiners, your supervisor and potentially other trainees. Your thesis is submitted as two bound volumes; volume 1 is the research thesis, volume 2 is the case reports. You submit two copies; one is kept in a locked cupboard in the department. The other is kept by the UCL library, but both volumes are stored off-site. Individuals can request to see your research dissertation, but the case reports are stored under conditions of “restricted access”, which means that they are not publicly accessible.

Despite this, it is essential that anyone reading the case report should be unable to work out the identity of your client. Achieving this requires some care, since it is surprisingly easy to include details that inadvertently breach confidentiality.

1) Do not use real names – these must be changed, and a statement indicating that this has been done should be included on the cover sheet.

Rather than inventing names, referring to Mr A., or Ms B. can be sensible; it makes it clear that these are not real names, and avoids the risk of reverting to the client’s real name if you invent a pseudonym. However, if there are a lot of people in the report, invented names become a necessity (there is a limit to how many Mr S’s, E’s and T’s the reader can keep track of), but make sure you proof read carefully and check that you’ve maintained the same pseudonym throughout.

2) Make sure that there is no information which could inadvertently identify the location of the service. For example, if the service has a particular name (“The Retreat”, “The Pathways Project”), this will identify the location where the client is being treated.

3) If you include letters or reports in the appendix, take care to remove all addresses, Trust logos and references to your name, the name of the patient or anyone involved in their care, and any professional involved in the case. You need to be somewhat obsessive about this, because it can be surprisingly easy to overlook names in the body of a letter.

You should include only necessary items of demographic and clinical information, and take appropriate steps to disguise some of it. However, you need to do this in a way that doesn't distort relevant issues. For example:

'a professional in her forties' *is much better than*
'the client was aged 43 and worked as a solicitor in a medium-sized law firm'

'he lives on a deprived inner-city housing estate' *is better than*
'he lives on a deprived inner-London housing estate', *which is better than*
'he lives in a tower block on a deprived housing estate in Dalston'.

Some details of the history (for example size of family, ages and sex of family members, occupation, timing of problem onset, specific details of the problem) may provide identifying information to somebody reading the work. This risk increases if the case includes a lot of specific and slightly unusual details which, taken together, could hint at a client's identity.

The more details you give, the more confidentiality is at risk. Equally, withholding information to preserve confidentiality can deprive the reader of crucial clinical information. There is a balance to be struck, and it is worth giving careful thought to this issue. In rare cases describing the case

properly would inevitably reveal the client's identity; if so it will be unsuitable for writing up as a report.

Client consent

The client's consent to the use of material for case reports should be obtained when this is possible. Currently there is a lot of debate about whether or not obtaining consent should be mandatory. Our position is that where consent is feasible, it should be sought. Equally we suspect that in some cases consent would be hard to obtain. In this way, being obliged to seek consent could restrict the choice of case could reduce the educational opportunities offered by case reports. At this stage we are reluctant to make a general rule about this, and discussion with supervisors on this issue will be important.

Informed consent means letting the client know:

- that they do not have to give you consent, and that withholding consent will not adversely affect their treatment
- that you will be writing up their case for educational purposes
- that their details will be disguised in order to preserve confidentiality
- that the report will be seen only by your supervisor, and by members of course staff and external examiners, all of whom are clinical psychologists
- that the report will be bound into your thesis, but will not be accessible to the general public
- that they can request to see a copy of the report (using the same procedures as for access to any medical record)

The two consent forms at the end of these guidelines (and in the Appendix to this handbook) make these points. One gives formal consent to the production of a case report, the other gives formal consent for recording of sessions.

If you are submitting a case report based on a recording, your client will have consented to taping, but may or may not have given formal consent for the report.

If your client does ask to see the report, you might need to give some thought about how this is best done (for example, taking them through the report, giving them a chance to question you on its accuracy and to discuss their responses to it).

Marking criteria

These can be found in Section 25 of the Training Handbook.

Submission of case reports as part of the thesis

The final versions of the case reports are submitted as Volume 2 of the thesis. The basic structure is:

- a) A title page, which states "Case Reports and Service-Related Research Project", then lists on separate lines your name, "D.Clin.Psy. thesis (Volume 2), [year of submission]" and "University College London"
- b) A table of contents, giving the full title of each report (there is no need to list tables and appendices).
- c) Each of the four case reports and the service-related research report, in the order in which each was submitted, formatted as follows:

- Title pages: for each case report, the title page should give the submission number, your own title (if you had one) and the type of case report, (e.g., Case report 4: “An angry young man” (Completed Clinical Intervention). For the service-related research the title page should read “Service Related Research Report (submitted as Case Report X)”; the title of the report is then listed on a new line.
- Word counts and trainee code numbers should be omitted.
- After the title page comes the body of the report, including references and any appendices pertaining to that report. Each case report is a stand-alone entity, so tables and appendices are numbered afresh (i.e. each report could have a Table 1, etc.).

PART 2: GUIDELINES FOR THE FORMAT OF REPORTS

General comments about the structure and content of reports

The comments below are *general* observations. The *specific* criteria for each style of report follow below.

It is important to think carefully about structure and content before you start writing. There is a discipline to writing clearly and concisely, guiding the reader to what is important, and leaving out irrelevant detail. Two fundamental questions to ask yourself are:

“What facts does the reader need to know about in order to understand the case, and what’s the best order for reporting them?”

“Which issues are critical, and which issues are interesting, but not strictly relevant?” This is a question about the focus of the report - particularly important given the word limit.

Reports should start with a *brief* introduction. This should orient the reader by a) setting out the main clinical and conceptual issues with which the report is concerned, and b) indicating the material to be covered.

Consider what aspects of the history and what relevant background information the reader needs. Try to be concise, but include enough detail so that the reader is supplied with *all* the basic facts they need at an early stage (a common fault is to embed relevant material at a later point).

Most reports will contain hypotheses about, or a formulation of, the case. These should fit with the history, and (as far as possible) explain how the problem developed, what is maintaining it, and (by implication) how it might change. They should be informed by psychological theory and relevant literature.

Take care to distinguish between facts that you know about, and speculation or opinion. Linked to this, be careful to identify the source of (and sometimes the evidence for) important facts. For example, a statement that the client had an “abusive childhood” could be based on a comment made by the patient, a passing reference in casenotes or the fact that their father was jailed for abuse – each of these has a very different status and meaning. Finally if the client's view of the problem is not consonant with your own or that of fellow-professionals, make sure that this is made clear (in other words, if you suspect that the client sees the “facts” of the case differently from you, this is important to note).

It is important that formulations and the report show some coherence in relation to the model you are using. For example, it would be odd to follow a comprehensive psychodynamic formulation with an account of a behavioural intervention. Equally inappropriate would be a report in which an intervention which claimed to represent one modality actually used techniques from an alternative approach, without acknowledging this as an issue.

Discussion of the intervention should try to show how the formulation and the intervention link together in a 'dynamic' manner. This usually means selecting relevant (i.e. illustrative) clinical material, and limiting yourself to details that are strictly necessary to showing your developing understanding of the case.

The concluding discussion depends on the type of report you have written, but will usually include some reflection on the work that you have done. This reflection can include consideration of wider issues raised by the case and its impact on you, as well as an appropriately

critical appraisal. In this context 'appropriate' means that you should not invent criticism for the sake of it. If the approach you took worked really well, there's no need for a critique. On the other hand, there is little in clinical psychology that is completely cut and dried, so it's often sensible to include suggestions about other ways in which the case could have been approached or managed. However, these should be realistic and feasible alternatives that could have been offered within the constraints of your experience and the service you are working in.

Using diagrams to illustrate formulations – a caution

All reports should include a text-based formulation. Diagrams should only be used to illustrate material that has already been alluded to in the text (for example to show the relationship between various elements in the presentation). They should not be used as a substitute for a full written account of the formulation.

If you do use a diagram it should be labelled as a figure, and referred to as such in the text.

Measures

You should include any methods you used to evaluate your work, and any numerical data you collected (raw data is usually included in an appendix).

It is good practice to report scores with confidence intervals (where these are available), as well as standard scores/ percentiles/ descriptors.

Wherever such data is available, there should be an indication of the clinical implications of any test results. For example, stating that a client has a BDI of 32 does not convey very much. Reference to normative data will tell you that this indicates a fairly high level of depressive symptoms. On this basis the score would be reported as:

"The client scored 32 on the BDI, which would indicate a high level of depressive symptomatology".

Another example might be:

"The client's score of 23 on the Recognition Memory Test places them at the 10th percentile".

If you have test results from previous recorded assessments, it will be helpful to contrast these with your results, and indicate the implications both of stability and of change.

References

Where relevant, you should cite pertinent literature. Bear in mind that the purpose of references is to give academic authority to your assertions, and to guide the reader to the source of major ideas that you are discussing. This should be done judiciously. We are not expecting a long reference list, and more references do not necessarily make a report more authoritative – their relevance to your discussion should be the basis for their inclusion.

COMPULSORY REPORT (CASE REPORT 1): ASSESSMENT REPORT

Aim

The aim of this report is to describe the assessment of a psychological problem, and the results of that assessment.

Competencies to be demonstrated

The report is intended to allow you to show that you have been able to plan and carry out an assessment that addresses the question(s) presented in a referral.

What the markers are looking for

The markers will be looking for evidence that you have identified the appropriate questions that need to be addressed, and used your theoretical and practical knowledge to plan a suitable approach to attempting to answer them. (In this context the use of theory is quite specific – this is described below in the section on content.)

They will want to see how you engaged the client in the assessment process, a clear rationale for the range of information gathered, and that this information is interpreted sensibly.

Examiners will expect hypotheses about the case, but won't expect a full formulation, especially if (as is likely) the assessment is only partly complete or the clinical work is at a very early stage. Distinguishing between a set of "hypotheses" and a "formulation" isn't easy – formulations are, after all, made up of hypotheses. In the context of the marking criteria, the distinction is made because:

- a) in the assessment phase any ideas you have about the client are probably tentative (you may well be missing some important information). This means that you are more likely to hypothesise, rather than to derive a fully-formed formulation (which may well be premature).
- b) formulations are internally coherent. In contrast, when attempting to make sense of ambiguous information, you may come up with a number of hypotheses, some of which are alternative ways of construing the case, some of which may even be contradictory.

If you are presenting a set of hypotheses, it is a good idea to indicate what additional information would be useful in order to clarify any areas of uncertainty, or decide between competing hypotheses.

Where you have used standardised measures, the markers will want to see that you have understood the properties of the measures and are aware of their strengths and limitations.

They will also want to see that you can reflect on and be appropriately critical of the assessment.

Type of material

Any type of case would be suitable. For example,

- an assessment for a direct or an indirect psychological intervention
- an assessment aimed at clarifying the nature of a presenting difficulty
- an assessment aimed at determining whether a problem is related to psychological or neurological factors

Assessments could be based largely on an interview format, could use formal procedures, or employ a mix of the two. The format will usually depend on the nature of the referral.

You can report on joint work, but if this is the case you should have been responsible for most of the work reported. You cannot report on work you have observed.

Content

Bearing in mind the general comments above, reports will usually include consideration of the following issues:

- The service context in which the referral took place, and the way in which this influences and shapes decisions about the scope of the assessment and the assessment procedures.
- How the assessment procedures used can answer the questions posed by the referral. For example, if psychometric tests were used, what were the reasons for choosing the tests? If the assessment was for psychological therapy, how and why was the interview conducted as it was? If a client was assessed on a ward, and information gathered from specific members of the ward team, what was the rationale for choosing who to talk to?
- What models were drawn on in conducting the assessment. Markers will be aware that in some settings a clear model is used from the outset, while in others a more pantheoretical approach is adopted. Whatever the starting point, as clinical facts emerge, theories and models will make certain lines of questioning more or less pertinent, and this sort of structuring is worth making explicit in your report. For example, if it became clear that the major problem was one of panic, a CBT model of panic disorder would lead you to ask certain sorts of questions, and you should (broadly) indicate how the model led you to these lines of inquiry.
- What information was gathered. This section needs to be structured so as to present a coherent account of the information gathered. A common challenge will be to decide which material is relevant, and which peripheral.
- Any 'process' issues which were pertinent – for example, difficulties in engagement, or ways in which a standard assessment procedure needed to be adapted to meet the needs of the client.
- How the information gathered clarifies the referral problem. How do you now understand the clinical problem, following the assessment and in the light of the information you collected?
- What clinical recommendations can be made on the basis of the assessment? How does your assessment help you to define what should be done next? What areas do you need to know more about?

In concluding the report it will be helpful to reflect on the assessment as a whole. This includes appraising what was good about your work, as well as being appropriately critical. However, there is no obligation to find fault – being 'critical' simply means being 'thoughtful'. This includes showing awareness of your own limitations at this stage of training, as well as any limitations which reflect the context within which you work. For example, while in an ideal world you might have talked to all members of a family, practical problems, or issue of confidentiality, might preclude this. A thoughtful discussion recognises these issues as realistic constraints. Setting unrealistically high standards for yourself or others would not be a good example of reflection.

Additional material which may be required

The results of standardised tests should be included in full in an appendix.

COMPULSORY REPORT: TRANSCRIPT-BASED THERAPY PROCESS REPORT

Aim

The aim is to show how you link the model of therapy you are applying to the process of the therapy you carried out. The core of the report is a reflective commentary, based on a transcript of your work.

Competencies to be demonstrated

The report allows you to demonstrate the ability to use clinical skills within a chosen and specified theoretical framework and provides evidence of your capacity to critically reflect on your own work as a clinical psychologist.

What the markers will be looking for

Although markers will be expecting the clinical material to demonstrate *basic* overall competence, this is not the main point of the report. The major focus lies with the commentary you offer, which will reflect on:

- what you were attempting to do
- how you did it
- any difficulties or issues which arose and
- the impact of the intervention both on you and on the client

Markers will pay particular attention to your ability to demonstrate links between the model you are using and the techniques you employ. As above, this does not mean that they expect you to apply them perfectly – only that you show an understanding of why you were doing what you did.

Content and suggested structure

a) Choosing appropriate material

Selecting appropriate clinical material is the critical initial step. You should be clear about the clinical themes and interventions you want to demonstrate, and be certain that the material will illustrate these.

It is best if material chosen for this report comes from a therapy which you are recording routinely. It is not helpful to record a sessions on a 'one-off' basis just to meet requirements for this report – both you and the client will probably be over-conscious of the recording process.

b) Choosing extracts from the recording

Usually the report will be based on a recording of a single clinical session. Given the word limit you cannot include all the material, so you will have to think carefully about what to include. The usual strategies are to:

- a) identify extracts from across the session which exemplify the themes which you wish to draw attention to, *or*
- b) select a continuous extract, again because it illustrates some relevant themes.

Alternatively you might want to focus on the way an important clinical issue or theme evolved over a number of sessions. On this basis, you could present short extracts from a series of sessions, rather than a single session. However, the extracts should be carefully chosen to illustrate both the clinical focus and its evolution.

Choosing appropriate extracts is important – they should be selected to illustrate the points you wish to make.

c) Overall structure of the report

i) Introduction

Start by outlining where the focus of the report will lie (and hence the reasons for choosing the extract(s)). For example:

This report will focus on a rupture in the therapeutic alliance, and the way in which this rupture helped to cast light on some important dynamics in the therapeutic relationship.

This report will focus on the use of guided discovery in the assessment of a client, and its value in helping to establish a more precise understanding of the client's problems.

After this you should outline the presenting problem (including a diagnosis where this is relevant), any other relevant issues relating to the client's background and the clinical context, and the assessment, formulation and intervention plan. You should identify the theoretical approach you are employing, and briefly review why you adopted this approach. You should also indicate the session number from which the extract is drawn (e.g. "this was the third session in a 15-session therapy"). In some cases it may be relevant to indicate the immediate treatment history that preceded the fragment you are presenting.

This section should not be too long – the idea is to set the scene, and give enough information to orient the reader to the case and to the clinical material.

ii) Extracts and commentary

Extracts should be transcribed, and speaker turns numbered to facilitate cross-referencing.

In most (but not all) cases it will be best to integrate the commentary with the transcript. If you do this, it is important to make it easy to distinguish the transcript from the commentary by using a different font or italics (and see comment below regarding the word count and transcripts).

You should then comment on the transcript, describing the therapeutic process as you understand it. For example:

- What I was intending to do was to assess the meaning of X to the client, though this seems to have been heard in a very different way by the client, who...
- I was trying to maintain a collaborative framework for implementing guided discovery, but the client seemed to react angrily to what I had thought were gentle probes...
- The client's specific reference to X suggested that this would be a good point at which to make an interpretation that attempted to draw their attention to the relationship themes which were central in the case formulation
- At this point the client seemed to withdraw into herself, and after what seemed a long silence I began to wonder if...

This commentary should track the transcript, trying to integrate:

- your sense of the therapy process and the skills you were employing
- your moment-to-moment intentions, e.g.:
 - what I was hoping to do here was to shift the focus from X to Y
 - because I thought this might raise the client's anxiety if broached too directly, I thought I'd start by raising issue A rather than issue B
- the way in which your subsequent actions are adapted to the client's reactions.

It is very important that the commentary should indicate how your interventions relate to the model you are applying. For example, you may refer to the model to help explain why you did something, or how you understand the client's reactions to your interventions. Bear in mind that your sense of being informed by your model would also be illustrated by noting where (and why)

you went “off model”. You are not expected to adhere perfectly to a model all the time; models are intended to inform, not to be followed blindly.

The commentary should also be appropriately reflective: as well as noting what went well you should also identify what did not go as well as intended, and try to account for these more problematic moments. Bear in mind that a reflective commentary is not a matter of simple self-criticism; it is more a matter of conveying your understanding of the ways in which the intervention might have worked better – for example, suggesting a rephrasing that might have been clearer to the client, or identifying possible reasons why the client might not have picked up on your intervention in the manner which you expected.

You do not need to comment on *every* exchange between yourself and the client unless there is a good reason for focusing at this level of detail.

iii) Concluding section

The final section of the report will be a reflection on the material as a whole. For example:

- the relationship between your intentions and the actual impact of your interventions
- your experience of trying to apply the specific theoretical framework
- any specific difficulties or dilemmas you experienced during the session

Word count and transcripts

The word limit **excluding** the transcribed extracts is 3000 words. The transcript itself should be a minimum of 400 words and a maximum of 1000 words

Guidelines on the recording

Although you do not need to submit the recording with the report, the examiners can ask for a copy, and you should ensure that this is available should they request it. It should be of good quality and the dialogue should be clear and audible.

Gaining consent for recording

Recording a clinical session requires the informed consent of the client. They must be made aware that the recording and commentary could be listened to by third parties at the University, and that this may include an external examiner.

Consent forms for recording and for the use of clinical material in a case report can be found at the end of this section.

The consent forms should be filed in the client’s casenotes. It should not be submitted with the report, as this would breach confidentiality by revealing the name of the client.

It is essential that steps are taken to safeguard the security and confidentiality of recordings. For example, a tape should be stored in a locked drawer, and any identifying labels should be coded (rather than using the client’s name). Care should be taken to ensure that digital recordings are not accessible to third parties – for example, they should not be downloaded and left on a computer hard drive. Increasingly Trusts are insisting on the use of encryption to assure client confidentiality – you should make sure that you follow local policy guidance.

OPTIONAL REPORTS 1: SINGLE CASE STUDY

Aim

The report is intended to give trainees the experience of conducting and writing up a case using standard single case methods (these will be covered in your research methods lectures). The aim is to demonstrate a systematic approach to monitoring client change over the course of intervention, with frequent, possibly session-by-session, applications of a simple quantitative measure of the client's behaviour or main problem.

Competencies to be demonstrated

The report allows you to demonstrate the ability to conceptualise and report on a case within the single case framework.

What the markers will be looking for

The markers will be assessing the ability to design, conduct and report on an intervention using single case methods.

Type of case appropriate to this report

A clinical problem or situation where systematic monitoring of client change is integral to treatment planning or intervention. The case should focus on a behaviour that can be quantified and measured regularly (usually by self- or other- observation) and should involve the application of a defined intervention. There will usually be clearly delimited baseline and treatment phases. The single case method may be applied in terms of a classic ABAB design, or could use another approach.

Examples of suitable cases include a parent training intervention to reduce a behaviour problem in a 4-year old child, a staff intervention to reduce challenging behaviour in a day centre setting for adults with learning disabilities, the acquisition of new learning for a client in a rehabilitation setting, or the monitoring of session-by-session change in a client with OCD.

Suggested content and structure

- a brief introduction to the general problem being addressed, with a review of relevant literature;
- a description of the clinical background, the details of the intervention, and a rationale for and a description of the methods of measurement;
- the results of the intervention, including a graph of the data (statistical analyses are not usually needed);
- a discussion of the outcomes. This should include some consideration of causality – i.e. a discussion which considers whether the intervention itself was responsible for any change in the client/system.
- some reflection on the utility of this approach in relation to the case as a whole.

Additional material

There are no specific requirements, but additional material may be presented in an appendix if required.

OPTIONAL REPORTS 2: ADVANCED ASSESSMENT REPORT

Aims

The aim of this report is to present a detailed account of a complex assessment, relating the work undertaken to psychological theory and outlining the implications of the assessment for clinical intervention.

Competencies to be demonstrated

This report allows you to demonstrate competency in assessing a reasonably complex case, integrating material from a range of sources and relating this to theoretical knowledge, showing a capacity to disconfirm possible explanations for presenting problems (or at least attempting to do so) as well as an ability to identify confirmatory evidence for any hypotheses.

Often – though not invariably - the assessment will be part of a multidisciplinary approach and so this report also allows you to demonstrate competency in working as part of a multidisciplinary team. The report allows you to show that you have been able to:

- find a way to focus on the necessary questions
- gather a suitable range of information
- interpret the results of the assessment
- distinguish between alternative “explanations” for the presentation
- provide feedback and clear recommendations to the client, client's family, referrer, and/or other colleagues, as appropriate.

Criteria for the report (type of material)

A very straightforward assessment would not be acceptable – for example, it would not be appropriate to report on a single session assessment using a WAIS to determine cognitive functioning in an individual who is already known to have learning difficulties.

The emphasis here is on an assessment which distinguishes between a number of non-trivial alternative explanations for a clinical presentation. For example:

- assessment of a child who is performing very erratically at school, where the aim is to answer questions about the factors which could be contributing to this picture
- assessment of a client in a CMHT with a long and complicated psychiatric history, where the aim is to clarify the nature of their presentation and hence to identify a treatment plan
- assessment of a person who is referred for “anxiety” and who presents with such a wide range of anxiety symptoms that it unclear what type of intervention is most likely to be of benefit, and where the aim of assessment is to arrive at a formulation which can be used to guide a focused treatment plan

Many (but not all) assessments will be carried out over a number of sessions.

Where an assessment is conducted in the context of team working the assessment process can include information from a range of sources, and also involve seeking the views of a range of workers who have had contact with the client or their carers.

What the markers will be looking for

The markers will want to see a detailed understanding of the theoretical and clinical issues raised by the referral, and (if relevant) of the multidisciplinary or service context within which the assessment takes place. There should be:

- a clearly identified set of aims for the assessment. This should include a description of the specific challenges posed by the assessment question
- (as relevant to the case) appropriate use and interpretation of measures
- a demonstration of your capacity to integrate information (for example, ‘triangulating’ information from different sources/ informants, or integrating assessment information)
- a psychologically-informed interpretation of results

Overall you should demonstrate that you can use the findings of the assessment to produce useful clinical recommendations, and show how these can be, or have been, acted on.

Suggested content and structure

The report should include:

- An account of the referral and presenting problem
- Aims of the assessment and a statement about the specific challenges posed by the assessment question
- An overview of any relevant theoretical literature.
- A rationale for the initial plan for the assessment, describing what questions you aimed to answer, and why, and detailing the various sources from which information was obtained.
- A description of the assessment process(es)
- An account of the information obtained and any pertinent observations made during the assessment(s)
- An integration of this information to provide likely answers to the questions posed and/or a comprehensive psychological formulation.
- A discussion of the clinical recommendations arising from the assessment, and how these were taken forward.
- A critical reflection on the work undertaken.

All advanced assessment reports should include a description of the ways in which findings from the assessment were used – this is as important a competency as the assessment itself. For example:

- how did you give feedback to the client and/or carers?
- how was information shared with the team and how was this received/acted on by them

Additional material

A brief description of any standardised or observational measures used, and a summary of the client's scores (raw scores and standard scores), should be included as appendices.

OPTIONAL REPORTS 3: THEORY-ORIENTED REPORT

Aim

The aim of this report is to show familiarity with the complexities of a particular theoretical orientation or framework.

Competencies to be demonstrated

This report allows you to demonstrate the ability to draw on psychological theory, at a reasonably sophisticated level, to understand clients' clinical presentation and to inform your practice.

What the markers are looking for

The report will be evaluated in terms of the quality and sophistication of the theoretical framework which you are able to bring to the clinical issue you identify. The markers will therefore want to see that:

- you can use the theoretical ideas to explain important clinical observations
- you can use the theory appropriately
- evidence associated with the theory is appropriately considered in relation to the case
- your understanding of the case is deeper as a consequence of this theoretical consideration
- the limitations of the theory are accurately and appropriately identified

The presentation of the theory itself separately from its integration with the clinical material is not an important part of the assessment – in other words credit would not be given for descriptions of the theory that were not related to the case.

Type of material

Any type of case would be suitable and any kind of clinical problem could be the subject of the report.

Suggested content and structure

The report should briefly outline the theoretical framework to be used. If relevant to the case it may be appropriate to identify any controversies concerning its status (for example, if the approach you adopted is not usually applied to the client group you are describing, or the evidence base for its use is very limited).

The report should start with a description of the case and the clinical problem that is to be addressed. The main focus of the report should be an integrative discussion of how the chosen theory illuminates aspects of the case – for example, the presentation, history, associated factors, the process of therapy or the outcome of intervention. The key word here is “integrative”, showing how theoretical ideas illuminate the clinical material and aid understanding, and the ways in which the theory helped the actual work.

If there are aspects of the case that are inconsistent with the theoretical formulation, this should be discussed and reflected upon, whether this reflects a concern with the application of the theory, or suggests limitations of the theoretical framework under consideration.

Additional material required

There are no specific requirements, but if necessary additional material may be presented in an appendix.

OPTIONAL REPORTS 4: A COMPLETED CLINICAL INTERVENTION

Aim

This report offers an opportunity to discuss in detail a whole treatment - from planning to implementation, and hopefully to follow-up, highlighting the decisions made and steps taken. The aim is to give evidence of your clinical reasoning and it is particularly important to highlight your thinking about your work and the considerations which have led you to make specific choices at specific times.

Competencies to be demonstrated

The report allows you to demonstrate the ability to report clearly on your clinical work, describing the decision-making processes that you followed and the way in which these informed both the design of the intervention and its subsequent adaptation in the light of the client's response.

What the markers are looking for

The case report is evaluated on the basis, not of the success of the work undertaken, but of the clarity and coherence of reporting of clinical material. It gives you an opportunity to demonstrate your capacity to describe:

- a) the process of clinical decision-making that leads to the design of a treatment intervention;
- b) the ways in which this intervention is re-appraised and modified in the light of the client's response.

While it is important for you to demonstrate that your work was guided by a particular conceptual framework, the *detailed* presentation of that framework need not be part of the report. Evidence of knowledge of the framework is expected to be implied by the decision making process described. Evaluation will focus on the clarity of reporting of clinical experience, the level of clinical thinking (both prospective and retrospective) reflected in the report, and the appropriateness and sophistication of the clinical interventions described (including the capacity to respond to unexpected consequences of clinical decisions).

Type of material

Any clinical intervention, whatever its outcome, in which you have been involved throughout the whole process from assessment to follow up, should provide appropriate material for this kind of report.

Suggested content and structure

Normally the report will contain the following sections, though the structure may vary somewhat, depending on the theoretical orientation of the report:

- Background to the case and the referral
- Initial ideas and hypotheses concerning the case, and assessment procedures implemented to confirm these hypotheses
- Conclusions based on the assessment, and your initial formulation of the clinical problem
- A detailed report of the intervention. If relevant, you should also describe any ways in which your thinking was modified as information emerged from the treatment – for example, how initial hypotheses were reframed or formulations revised.
- Brief report of outcome
- Reflection on the case as a whole

Normally the background information would be kept to a minimum and your clinical thinking both during and after the intervention would be given the most weight.

Additional material required

There are no specific requirements, but it is expected that the report will make appropriate links/reference to relevant literature.

OPTIONAL REPORTS 5: AN IMPASSE IN A PSYCHOLOGICAL INTERVENTION

Aim

The aim of this report is to focus on a case where there were significant difficulties in implementing an intervention. There are various dictionary definitions of an 'impasse' - for example, a situation that is so difficult that no progress can be made; a deadlock or a stalemate. The word 'impassable' is derived from the word *impasse* – to mean (for example) a road or passage having no obvious exit; like a cul-de-sac.

In the context of psychological interventions the word 'impasse' is used to indicate that a major obstacle has emerged which, if not addressed, could represent a major threat to the maintenance of therapeutic contact.

Examples of an impasse might be:

a client who had been making good and steady progress who suddenly becomes angry and sullen for no reason that you can (initially) detect

a client who has been attending regularly who starts missing sessions for no clear reason

a client who readily agrees to carry out behavioural experiments in the session, but never carries them out in practice

a client who says they can only continue if you are able to be a friend to them, rather than a therapist

Impasses are not simple perturbations in the therapy – for example a single incident where the client seems puzzled about something and you resolve matters very quickly. An impasse is usually a major impediment that could derail the therapy if not attended to.

Competencies to be demonstrated

The report allows you to demonstrate skills in managing impasses in clinical work, including the ability to recognise such situations as they arise, to use your theoretical knowledge and clinical experience to understand the possible reasons underlying these developments, to identify an appropriate course of action, and to reflect on the work undertaken.

What the markers are looking for

Because this report focuses on the management of impasses, a good report will demonstrate competence in the capacity to:

- recognise the presence of an obstacle to implementation of an intervention;
- draw on relevant academic and clinical knowledge in order to understand the nature of the problem, and to derive a working formulation of the issues;
- translate this formulation into a set of actions appropriate to the clinical context;
- articulate the above in a coherent and reflective manner, including any broader implications for clinical practice.

Type of material

Examples of relevant situations could include cases where:

- major challenges to the therapeutic alliance emerged
- a client's complex social problems made the delivery of the psychological intervention problematic
- the client aroused strong personal feelings in you as therapist, with implications for your capacity to deliver the intervention

- indirect interventions were threatened by the antipathy of a staff team
- serious difficulties emerge in applying the theoretical model being adopted

Although many impasses emerge only when treatment is under way, reports could also cover instances where major obstacles to engagement had to be surmounted before an intervention could begin, and where intervention based on an understanding of these obstacles was critical in sustaining contact. They could also consider situations where it becomes clear that difficulties in implementing an intervention indicated the need for a major revision in the approach taken.

Reports that discuss unresolved impasses will be as welcome as those where the impasse is overcome.

Suggested content and structure

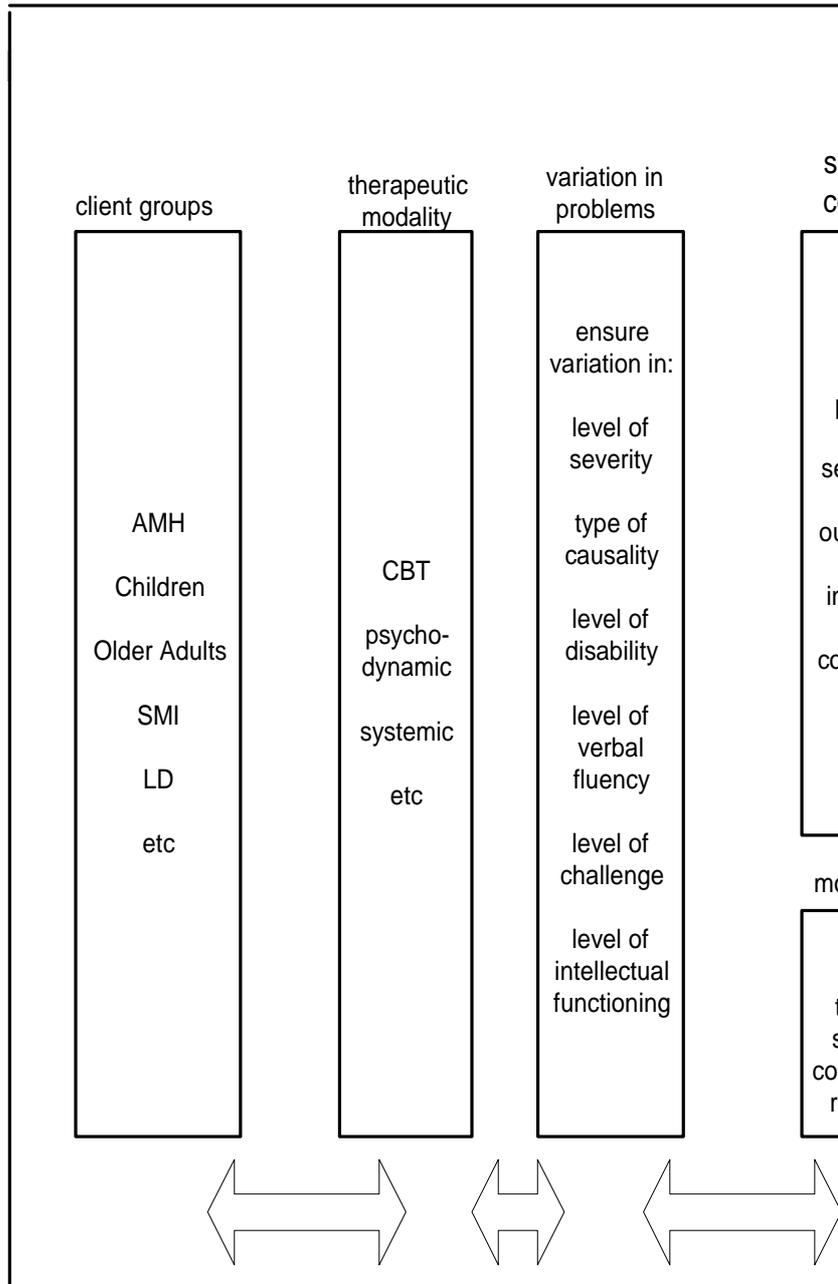
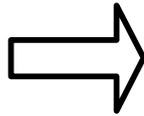
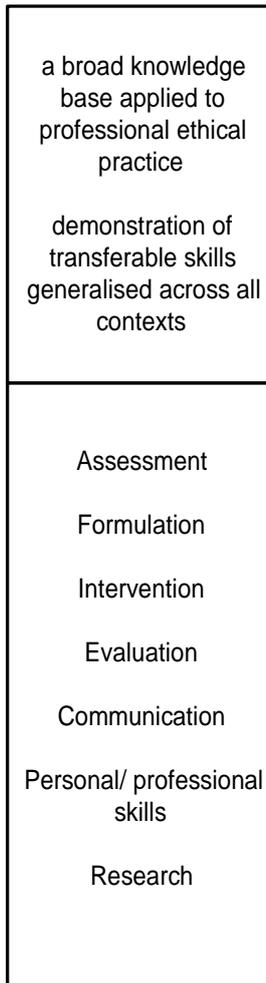
This report will usually:

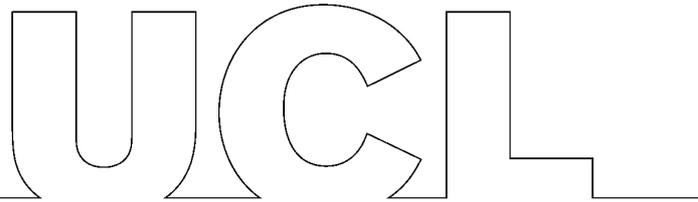
- identify the nature of the impasse and review relevant clinical and theoretical literature;
- describe the clinical context within which the impasse developed;
- offer a formulation or hypotheses about why the impasse has emerged;
- describe the ways in which resolution of the impasse was attempted; and
- consider the outcome and any further steps that may be recommended or proposed.

Additional material required

There are no specific requirements, but if necessary, additional material may be presented in an appendix.

iterative competencies





University College London Doctoral Course in Clinical Psychology

Client consent form - clinical case report

Your therapist is a trainee Clinical Psychologist. They are based in the NHS and also registered with University College London (UCL), undertaking a Doctorate in Clinical Psychology.

As you know, your psychologist’s work is being supervised by an NHS Clinical Psychologist. In addition to this supervision, your psychologist needs to submit reports of their clinical work to UCL (to show the University that they are working effectively and appropriately). These are known as “case reports”. Once submitted, case reports are stored at UCL (in a “restricted-access” area of the library and in the Clinical Psychology Department). This means that they cannot be looked at by the general public.

Your psychologist will have let you know that they would like to produce a case-report that describes their work with you. This consent form is a formal way of indicating that you agree to this, and that you understand that the report:

- is being written for supervision and assessment for educational purposes
- will only be looked at by your psychologist’s supervisor and by assessors at UCL (who are qualified Clinical Psychologists)
- that you can request to see a copy of the report, in the same way that you can request to see any other clinical reports written about you

Confidentiality

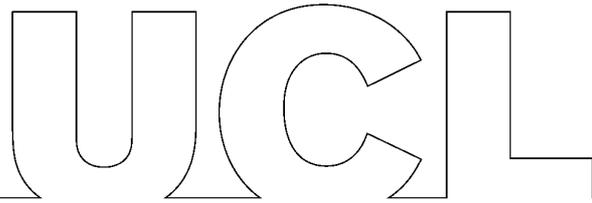
Your psychologist will have explained that the case report will be written in a way which makes sure that no-one can identify that the report is written about you. This means (for example) that your name will be changed, and any information which could be used to identify you, your family or anyone else involved in your case will also be removed or changed. The idea is that no-one should be able to identify who you are when they read the report.

	please tick
I understand that I am not obliged to give consent, and that if I do not want to this will not affect my treatment	
I agree to the preparation of a case report based on my treatment	
I understand that the report is being written for the purposes of supervision and education	
I understand that the report will be seen only by my psychologist’s supervisor and by psychologists at University College London	
I understand that I can request to see a copy of the report in the same way as I can request to see any clinical reports which relate to me	

Name and signature of trainee psychologist:

Name and signature of client:

Date:



University College London Doctoral Course in Clinical Psychology

Client consent form for taping of clinical sessions

Information for clients

Your therapist is a trainee Clinical Psychologist. They are based in the NHS and also registered with University College London (UCL), undertaking a Doctorate in Clinical Psychology.

As you know, your psychologist's work with you is being supervised by an experienced NHS Clinical Psychologist. One way of improving the quality of this supervision is to tape-record sessions. Listening to a tape gives supervisors a much more accurate idea of what is happening, and in this way helps your psychologist to help you.

Unless your psychologist explicitly indicates otherwise:

- tapes of your session will only be listened to by your psychologist's supervisor
- tapes will only be used for the educational purpose of supervision
- recordings will be deleted once their educational purpose has been completed

Some clients find it very helpful to listen to a recording of their sessions. You may wish to have a copy of the tape for yourself. If you would like a copy, discuss this with your psychologist.

On occasion trainees may wish to use tape recordings to help them write clinical reports. If this is the case this will be discussed with you, and you will be asked to complete a separate consent form.

	Please tick
I understand that I am not obliged to give consent, and that if I do not want to this will not affect my treatment	
I agree to the tape recording of my sessions	
I understand that the tape recording will be used for the purposes of supervision and education	
I understand that the tape recording will be deleted once its educational purpose has been completed	
I understand that I can ask for a copy of the tape	

Name and signature of trainee psychologist:

Name and signature of client:

Date:

APA Citation and Referencing Style

Citations in the text

Several publications on qualitative research methods (Elliott, Fischer & Rennie, 1999; Smith & Osborn, 2008; Willig, 2008) discuss ...

- citations within a bracket are in alphabetical order (not date order)
- citations are separated by semicolons; authors and date are separated by a comma
- cite multiple authors in full the first time; use et al. (note the punctuation) thereafter (but if there are six or more authors, use et al. throughout)
- use an ampersand (&) within the bracket (and in the reference list), “and” otherwise.

Reference lists

Journal article

Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Chapter in a book

Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 53-80). London: Sage.

Complete book

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Buckingham: Open University Press.

- note usage of punctuation, italics and ampersands (&)
- book titles are in lower case; journal titles in title case
- no part numbers needed for journal articles

Frequently asked questions

How do I cite a secondary source?

If you cite a paper in the text, you are assumed to have read it yourself. If it is a hard-to-obtain reference (e.g., a conference presentation) which you have seen cited elsewhere but not read yourself, cite both the primary and the secondary source. For example, if you want to cite Bloggs

(1978), which you saw referred to in Jones (2006), then your citation would be (Bloggs, 1978, cited in Jones, 2006).

How do I cite an unpublished document?

For an unpublished document, the citation in the text should give the date, and the reference should give the reader information on how to locate the document. For example, for the following DClinPsy thesis, the citation is Saunders (2008) and the reference is:

Saunders, H. (2008). *Effects of expressive writing on physical and psychological symptoms in women undergoing surgery for gynaecological cancer*. Unpublished clinical psychology doctoral thesis, Department of Clinical, Educational, and Health Psychology, University College London.

How do I cite a website?

If you are citing a web page, your reference list needs to give the full URL (i.e. the web address). For example, if you are citing the NICE guidelines on depression, in the text give the citation as (NICE, 2010), and in the reference list, give it as:

NICE (2010). *Depression: the treatment and management of depression in adults (update)*. Retrieved from <http://www.nice.org.uk/CG090>

Further details

American Psychological Association (2010). *Publication manual* (6th ed.). Washington, D.C.: American Psychological Association. [There is a reference-only copy in the trainee library.]

<http://www.apastyle.org> [This site has a good Frequently Asked Questions list and also an online tutorial.]