CASE REPORT GUIDELINES 2017

Aims

Clinical Psychologists are trained to be reflective, scientist practitioners and your academic work should demonstrate this. Case reports show a process of academic learning based on each module learning outcomes, demonstrating how assessment leads to formulation, generation of hypotheses, then choosing the most appropriate evidenced-based intervention(s), and monitoring the effectiveness of treatment using patient reported outcome measures (PROMS)[1].

Case reports provide evidence of:

a) your clinical knowledge and competence across a range of different types of work and setting, in the context of a range of theoretical perspectives and therapeutic modalities.

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 apply to your clinical work.

Formats

Throughout the DClinPsych programme you will complete a total of three case reports, one each year. You will submit a different type of report during Years 1 and 2 from CBT, Process Analysis or Systemic perspective. **One of these must be a CBT case report.**

The formats for the reports are as follows:

Year 1) The first case report (submitted during the second term of the first year) must either be a CBT or a Process Analysis case report (the latter is based on a transcript, of an audio-recording of a clinical session, then reflecting on the therapy process contained therein).

Year 2) The second case report (submitted during the second term of the second year) will either be a CBT/Systemic case report or a Process Analysis case report.

Year 3) The third case report (submitted during the second term of the third year) will be the Major case report. The defining feature of this case study is that you must demonstrate your ability to have developed into a reflective scientist practitioner. Within this you could incorporate features of the process analysis, single n approach to case evaluation, group interventions, consultation or multidisciplinary interventions.

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[1] Kendrick T, El-Gohary M, Stuart B, Gilbody S, Churchill R, Aiken L, Bhattacharya A, Gimson A, Brütt AL, de Jong K, Moore M. Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults. Cochrane Database of Systematic Reviews 2016, Issue 7. Art. No.: CD011119. DOI: 10.1002/14651858.CD011119.pub2.

Breadth of content

By the end of the Course you will have a "portfolio" of 3 case 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 so choosing a different focus for each case report is necessary.

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 nonetheless, it is a good idea to think ahead and to try to plan for as great a diversity of reports as your placement experiences permit.

In summary, in the "portfolio" of case reports you should ideally seek to include:

- cases drawn from across the lifespan (child / young person v adult v later adulthood)
- variation in severity and chronicity of presentation (acute onset through to serious and enduring presentations)
- variation in psychological approaches (you should be able to demonstrate competence in more than one model of formal psychotherapy)
- variation in settings (primary care, secondary or tertiary/specialist; inpatient / outpatient)
- at least one report demonstrating inter-professional working (direct or indirect work with another professional or with members of a multi-disciplinary team)

Statement of Authenticity

Submission of clinical reports needs to be accompanied by a signed Statement of Authenticity from the clinical supervisor. This may be provided as a hard copy or may be scanned and emailed to n.henderson@qub.ac.uk by 10am on the submission date.

You should not ask your supervisor for feedback on the report, and they should not offer it. Their role is solely to confirm that the report is an accurate representation of the work undertaken, not to comment on your (or indeed their) understanding of the case.

Quality of writing, grammar and spelling

Written work submitted should be clear, with no spelling or grammatical errors, or errors introduced because 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 focus. However, 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.

CHOOSING A CASE

The ability to make links between theory and practice, to reflect on the work undertaken and to show appreciation of any issues raised by the clinical material are key. 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 pleasing to read about successful outcomes, the report is not a test of your ability to make things better rather the focus is on your analytical skills and application of psychological knowledge.

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, i.e. 2-3 sessions. You need to demonstrate some intervention so it is useful to have completed some of the treatment plan.

Case reports do not need to be based on "complex" cases, or ones that are especially "interesting". Routine casework is fine, and 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 can be less or more challenging. We strongly recommend that before you start writing you talk to your personal tutor / the module coordinator about the case you have in mind. However, tutors cannot look at a draft of the report (because all reports are blind marked, they could be marking it).

MAINTAINING CONFIDENTIALITY

Although there is restricted access to case reports it is essential that anyone reading the case report should be unable to work out the identity of your client. Achieving this requires great care, since it is surprisingly easy to include details that could (however inadvertently) breach confidentiality. Some tips may be helpful:

1) Never 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, it makes more sense to refer to "Mr A"., or "Ms B". because this makes it clear that these are not real names. It also removes any 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. Less obviously, even giving broad geographical information can narrow down the location of the service. For example, reference to a 'a secure forensic unit in Belfast' (since there is only one forensic service in this area), would compromise confidentiality. In this case 'a forensic service' is all the information that is needed.
3) If you include letters or reports in the appendix, take great 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 obsessional about this, because it can be surprisingly easy to overlook names in the body of a letter.

4) You should include only necessary items of demographic and clinical information. You can usually do this quite easily without distorting relevant facts - two examples show how:
   1) 'The client is a professional in her early forties' is better than: 'The client is aged 43 and works as a solicitor in a small law firm'
   2) 'The client lives in a large and run-down housing estate' is better than: 'The client lives in a deprived housing estate in north Belfast '.
5) Providing 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 unusual details which, taken together, could reveal a client's identity.

Bear in mind that 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. However, if describing the case properly would inevitably reveal the client's identity; it will be unsuitable for writing up as a report.

GAINING INFORMED CONSENT FROM CLIENTS FOR CASE REPORTS AND FOR RECORDINGS

Consent is the voluntary and continuing permission of the client to receive an intervention. Trainees enrolled on an educational programme means that there are some additional factors that clients need to be aware of when granting consent - in particular the fact that their clinical material will be discussed regularly with supervisors, and may also be discussed with programme staff, or written-up in the form of a case presentation or case report.

Before describing how consent for case reports is obtained, it is helpful to revisit some basic issues:

Who can give consent

All clients over 16 years are presumed to be able to give consent for themselves, unless it can be demonstrated that they lack the capacity to do this.

Clients who lack capacity to give informed consent

Some adults may find it difficult or lack the capacity to give or withhold consent for themselves – for example, they may have impaired cognitive capacity due to brain injury, learning disabilities or dementia, or severe mental health problems.

Judging capacity is not always straightforward and before concluding that a client lacks capacity to consent to a decision, every effort should be made to try to communicate with them and provide information in a manner that supports their ability to decide on their own. If someone is mentally competent to give consent but is physically unable to sign a consent form, then an independent witness can be asked to confirm that the patient has given oral consent.

If it is not possible to gain consent from the individual concerned, then any proposed intervention must be deemed to be in the client's best interests. Usually this will involve discussion with appropriate members of staff (such as relevant professionals involved with the client, your supervisor (etc)) as well as relatives or advocates.

Children under 16 years old

When working with children under 16 years old, parental consent must be obtained. If a child under the age of 16 years has sufficient understanding they may sign a consent form for themselves. Wherever possible it is good practice to involve the child – it is best for work to take place with the consent of both child and parent/carer.

Gaining consent from families or groups

This is achieved using the same principles as for individuals, adapted to the service context and the age and capacity of the individuals concerned.

PROCEDURE FOR GAINING CONSENT TO THE USE OF CLINICAL MATERIAL IN A CASE REPORT

Clients should give consent to the use of material for case reports (the word 'client' can refer both to a single or to multiple individuals). The case report could be seen as equivalent to a clinical record: as such clients are entitled to know that such a record has been created, and be in a position to consent to the use to which it has been put.

Consent procedure

It is usually best to obtain consent for case reports at the start of an intervention, and integrate this request with the process of obtaining consent for the intervention itself. Consent does not need to be revisited at a later stage of the intervention (when decisions have been made about which report to write) unless there is an explicit reason to think that the client may have reconsidered consent - most obviously when clients raises the issue explicitly. However, references that could be interpreted as an unexpressed concern or worry about the report should not be ignored. In such circumstances, it would usually be best to have a discussion with the supervisor and consider how best to proceed.

Trainees should ask clients to complete a written consent form specifically for the case reports, and be prepared to answer any questions the client has about its content.

GAINING CONSENT FOR RECORDING SESSIONS

Session recording should never take place without a client's consent. In considering whether to agree to this, clients will want to know why the recording is being made, the uses to which it is being put, the precautions taken to ensure that it is kept secure, and the arrangements for its 'disposal'. These issues are outlined in the consent form, and trainees need to be prepared to discuss them with clients and to answer any questions.

Ensuring the security of session recordings using encryption

It is Course policy and a legal requirement to encrypt personal data that relates to clients (or indeed to research participants or any other individuals with whom trainees work in a professional capacity). This ensures that data cannot be accessed by unauthorised third parties, a particular risk if the storage device (such as a memory stick, computer or digital recorder) is lost or stolen (the most common cause of security breaches).

Course policy is that recordings are only stored in encrypted form on an encrypted memory stick with an integrated passcode facility. It follows that unencrypted recordings should never be stored, either on a digital recorder or on an unencrypted memory stick.

Some Trusts will provide encrypted memory sticks and/or voice recorders, and in some settings recordings, can only be made/transferred using these sticks/recorders. It is important to follow Trust policy if such restrictions exist and alternative arrangements are not permitted. However, we understand that the procedure set out below conforms to NHS Information Governance standards.

Encrypting digital recordings using a standard digital recorder and an encrypted memory stick with an integrated passcode facility

Trainees must follow the procedure outlined below when using a standard digital recorder (clearly if the recorder has built-in encryption the following steps are not required).

Step 1: Set a strong (i.e. long) passcode onto the stick (you should not use a short code or one that is easy to recall (e.g. 1,2,3,4,5,6)

Step 2: Record the session using a digital voice recorder

Step 3: Immediately following the session, transfer the recording to the encrypted USB stick

Step 4: Immediately delete the file from the recorder

Step 5: When replaying the recording, do so only from the USB stick. Never transfer the recording to a computer, as this would require it to be decrypted (this would defeat the whole exercise, as it would create an unencrypted file!)

Step 4 is absolutely critical, and should take place as soon as is practical after the recording is made – if you leave the recording on an insecure (unencrypted) device it is at risk.

GUIDELINES FOR THE PRESENTATION OF CASE REPORTS

General comments

It is important to think carefully about structure and content of coursework 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, and what’s the best order for reporting them?”

Reports should start with a brief **introduction**. This should orient the reader, to the primary focus of the report and the main clinical and conceptual issues with which the report is concerned.

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.

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 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, and if necessary a critical appraisal of work undertaken.

Using diagrams to illustrate formulations

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 at assessment and for evaluation 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".

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.

SPECIFIC GUIDANCE FOR CBT CASE REPORT

A defining feature of clinical psychologists is their ability to use a broad evidence and knowledge base, to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention.

It is recognised that the realities of clinical practice mean that an intervention may incorporate elements of other evidence based approaches. However, in this assignment you should demonstrate competencies in drawing from the knowledge base, assessing, formulating, conducting interventions and evaluating **primarily** from a CBT perspective.

The type of competencies you are required to demonstrate in this case report can be found here:

https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/cognitive-and-behavioural-therapy

For further information on structuring the CBT case report also see http://journals.sagepub.com/home/ccs (Journal Clinical Case Studies) where you will find examples of relevant case studies.

SPECIFIC GUIDANCE FOR SYSTEMIC THERAPY CASE REPORT

A defining feature of clinical psychologists is their ability to use a broad evidence and knowledge base, to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention.

It is recognised that the realities of clinical practice mean that an intervention may incorporate elements of other evidence based approaches. However, in this assignment you should demonstrate competencies in drawing from the knowledge base, assessing, formulating, conducting interventions and evaluating **primarily** from a systemic therapy perspective.

The type of competencies you are required to demonstrate in this case report can be found here:

https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Systemic_Therapy

SPECIFIC GUIDANCE FOR PROCESS ANALYSIS CASE REPORT

Extracts should be transcribed with speaker (client or therapist commentary) turns numbered to facilitate cross-referencing. The therapist commentary should be in italics to distinguish it from the dialogue of the client. You should then analyze the transcript and comment on it, describing the therapeutic process from your own perspective.

The transcript itself should be a minimum of 400 words and a maximum of 1000 words

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.