About PCSP

Instructions For Authors

1) Type of manuscripts sought. As described in the About section, we seek manuscripts in the areas of individual case studies; multiple case studies; analytical or critical comparative reviews of previously published case studies, particularly those that have been published in PCSP; and case study method. A manuscript can cover either one case or a series of cases of a particular type. All cases have to be described in systematic, qualitative detail. Client scores on standardized, quantitative measures at the beginning, during, end, and follow-up of therapy are highly desirable where feasible and consistent with the theoretical approach employed. Such scores normatively contextualize a case.

2) Format. In the beginning phase of the journal, all manuscripts should be submitted doubled-spaced in Word with Times New Roman 12-point type and with 1" margins all around. Manuscript length is flexible, but is generally expected to range between 30 and 60 double-spaced pages. Otherwise, the manuscript should follow the guidelines of the Publication Manual of the American Psychological Association.

3) Method of submission: In the beginning phase of the journal, all manuscripts should be submitted by email attachment to the Editor, Daniel Fishman at: DFish96198@aol.com.

4) Case study method: Case study method manuscripts may be philosophical, theoretical, or analytical concerning the epistemological, moral, or philosophy-of-science issues raised by case study research. These manuscripts may also be quite technical or methodological dealing with very specific ways or means of improving the quality of case study research or case study reporting. Such articles may or may not actually contain new clinical case study material as a means of illustrating the relevant arguments.

5) Critical reviews of previously published case studies. Review articles that identify striking similarities and differences across multiple previously published case studies are sought when these contribute to our understanding of psychotherapeutic processes and outcomes in ways not initially revealed in the original publications. These are particularly sought when the cases were previously published in PCSP. Such articles may indicate contradictory findings, the emergence of inductive generalizations across multiple case studies, or previously ignored deficiencies in the conduct or reporting of case studies.

6) Common headings in case study manuscripts: We strongly prefer case study manuscripts to be organized in terms of the following headings. The first 9 are strongly recommended, and the last two are optional.

1. Case Context and Method
2. The Client
3. Guiding Conception with Research and Clinical Experience Support
4. Assessment of the Client's Problems, Goals, Strengths, and History
5. Formulation and Treatment Plan
6. Course of Therapy
7. Therapy Monitoring and Use of Feedback Information
8. Concluding Evaluation of the Therapy's Process and Outcome
9. References
10. Tables
11. Figures

Suggested details for the content of common headings 1-8 are provided below, after Figure 1.

The rationale for common headings is explained in the About section as follows:

In order to facilitate comparison among cases, it is important to strive for a common framework and structure - embodied in common headings --within each case. The editors of PCSP have chosen to begin their project by encouraging authors to use a framework developed by Donald Peterson (1991) titled "Disciplined Inquiry." This model has been chosen because it can accommodate (a) a wide array of different theoretical approaches, such as cognitive behavior therapy, psychodynamic therapy, humanistic therapy, and family systems; (b) the whole continuum defined by highly manualized treatment models at one end, highly individualized therapy at the other end, and some type of synthesis in the middle (e.g., Davison, 1998, Persons, 2003); (c) and a variety of models of how the most effective practitioners in many fields actually function (e.g., the models of Sch�n [1983] "reflective practitioner" and Stricker & Trierweiler's [1995] "local clinical scientist").

Briefly, Disciplined Inquiry requires the practitioner to lay out his or her "guiding conception" of therapy, as informed by published research and the practitioner's clinical experience. This guiding conception is then employed to create an individualized assessment, formulation, and treatment plan for the client. Interventions are then carried out -- with appropriate monitoring and feedback -- until termination, follow-up, and a concluding evaluation.

More particularly, Figure 1 (see below) presents a diagram of the major components, A-L, of Disciplined Inquiry. The figure shows how common headings 2-8 above are logically interrelated. Specifically, the case study begins with a focus on the client's presenting problems and situation (component A). In the context of components B and C -- the therapist's guiding conception of therapy and therapy process for this type of client, along with the relevant research literature and the therapist's previous clinical experience -- the client is then assessed (component D). (Note that the relevant research can include a variety of types of information, such as client factors, therapist factors, "common factors" associated with the process of therapy, and evidence from empirically supported treatments.) The assessment then leads to a case formulation and associated treatment plan (component E), which in turn guides the interventions (component F). Here, too, research and experience (C) are relevant for both selecting interventions (E) and conducting them (F).

Next, a monitoring evaluation (G) is conducted. This can be based on a discussion between client and practitioner of what has been accomplished and/or a review of ongoing quantitative monitoring information that has been collected (such as the administration of a client self-report questionnaire at the beginning of each session, or formal therapist ratings at the end of each session.) and/or formal testing of the client. If either client or therapist considers the outcome insufficient (K) and expects further efforts to lead to greater improvement, the case may be reformulated (E) and new interventions (F) attempted either by the same or another therapist. If both the client and the therapist consider the outcome satisfactory and the client's needs are met (H), the therapist proceeds to termination and a concluding evaluation (L). (Another reason for proceeding to a concluding evaluation would be if, for some other reason, the client and therapist cannot agree upon the desirability of continuing.) The case then becomes (via J) part of the psychologist's accumulated repertoire of clinical experience (C), which influences how future cases are treated. Results that differ from expectations may require a change or accommodation (I) in the guiding conception (B).

Figure 1. Professional activity as disciplined inquiry
(adapted by Fishman [1999] and Messer [2004] from Peterson [1991])

Suggested details for the content of common headings 1-8 are provided below.

1. Case Context and Method.

In this section the author should describe:

A) The rationale for selecting this particular client for study. Sample rationales are (a) randomly drawing a case from a larger research study, (b) selecting a case as representative of a "typical" outcome, (c) selecting a case because of a distinctively excellent or poor outcome, (d) choosing a case to illustrate a particular Guiding Conception, or (e) choosing a case to illustrate certain theoretically interesting points.

B) The methodological strategies employed for enhancing the rigor of the study. Examples are suggested in Fishman (2000) and involve such strategies as: (a) including copious notes within the study; (b) audiotaping or videotaping therapy sessions so that they can be studied systematically after the fact and be made available to other, independent assessors; (c) in the spirit of triangulation, employing quantitative, client self-descriptive questionnaires, the data of which are kept blind from the therapist and only "opened up" after the qualitative analysis of the case has been completed; (d) also in the spirit of triangulation, having an independent researcher assess the client before, during, and after the therapy, without sharing that information with the therapist until the therapist or another independent researcher has written up the case; (e) having an independent "research auditor" check to see if the author's conclusions seem supported by the data provided, or perhaps by access to additional detailed notes or the therapy tapes themselves; (f) having separate assessors review all the tapes and write up their versions of the therapy independently, with these multiple "case views" then systematically cross-analyzed; and/or (g) having clinical supervisors or a clinical team comment on their views of and input into the case.

C) The clinical setting in which the case took place. This includes such factors as (a) referral source; (b) other community service providers who were involved; and (c) the kind of treatment setting (such as public vs. private; inpatient vs. outpatient; fee for service vs. managed care; and professional office vs. training facility).

D) Sources of data available concerning the client. This can include such material as educational or medical records, information from significant others, and prior treatment reports.

E) Confidentiality. This section describes the precautions that were taken to prevent disclosure of the client's identity, and whether the client consented to publication.

2. The Client. This section describes (a) who the client is (although properly disguised); (b) the historical and contemporary context of the client's life; and (c) the nature of the client's presenting problems and goals. In this and all subsequent sections the author's assertions must be qualified by statements indicating the degree of certainty attaching to the claims (Bromley, 1984).

3. Guiding Conception, with Research and Clinical Experience Support. This section lays out the therapist's guiding conception, along with the links between the guiding conception and the published research literature and the author's past clinical experience. The guiding conception should include:

A) An understanding of the nature of this type of client's presenting problems, and how specific interventions and/or general strategies can alleviate them.

B) The model's view of the therapist's role, the therapist-patient relationship, and other "common factors" in the therapy.

C) The relationship between categories 4-7 below (i.e., assessment, formulation, course of therapy, & therapy monitoring) and the chronology of the therapy. That is, the author should describe whether the guiding conception views therapy as proceeding in roughly the order of categories 4-7, or whether there is a discrepancy between the sequence of the categories below and the sequence of therapy process. If there is such a discrepancy, the author should (a) describe the nature of the discrepancy; and (b) present the case in a clear and systematic fashion indicating in detail the nature of the problem, the process of the therapy, and the outcome of that process.

D) The therapist's prior experience with similar cases and, if applicable, his or her specific clinical training that may be relevant to this work.

4. Assessment of the Client's Presenting Problems, Goals, Strengths, and History. In this section, the guiding conception and previous research and clinical experience are employed to direct the individualized, systematic assessment of the client's presenting situation, personality, problems and goals, strengths, and personal and family history. More than just recent life-history information is desirable. Not all cases will be required to provide a complete developmental history of the client, but wherever possible such information should be provided. Note that the focus in the assessment is on a description of the client and his/her situation, while the focus in the formulation and treatment plan (see below) is upon an interpretation of the client and his/her situation.

5. Formulation and Treatment Plan. In this section, the client's problems and their origins and/or the mechanisms of sustaining them are set forth in an individualized formulation. This leads to an individualized treatment plan.
Note that in Figure 1 above, the formulation and treatment plan flow from applying the generic theory in the guiding conception (section 3) to the case specifics that emerge from the assessment (section 4). Thus, the section describing the formulation and treatment plan should spell out the logical links they have to the material in sections 3 and 4. (For some examples of case formulation models that are embedded in different theories [i.e., in different guiding conceptions], see Eells, 1997).

6. Course of Therapy.

A) In this section, the course of therapy should be described in terms of how at least three functions -- rapport/alliance-building, assessment, and intervention -- play out over the temporal course of the therapy. In other words, at one end of the spectrum, the three functions are conducted in temporal sequence, with rapport/alliance building coming first, then assessment, and then intervention; at the other end of the spectrum, the three functions are viewed as in continuous interplay; and there are then all sorts of positions in the middle of these two poles.

B) Two general types of process should be included in the description: (a) the therapy relationship (including rapport/alliance-building behaviors, attitudes, and strategies of the therapist), the responses of the client, and the interactions themselves between therapist and client; and (b) the specific therapeutic strategies and procedures employed by the therapist, and the client's reaction to them. It is particularly valuable if verbatim transcripts can be excerpted to illustrate the therapeutic process at critical junctures.

C) As the course of the therapy is described, the links between the Guiding Conception and the ongoing therapy interventions and process should be explored and analyzed.

D) Included should be a description of confounding factors or unanticipated difficulties in the therapy. These can include such events as (a) personal reactions of the therapist to the client (referred to in some models as "countertransference"); and (b) disruptions in the therapy from outside sources (such as insurers, relatives of the client, and health problems of client or therapist).

7. Therapy Monitoring and Use of Feedback Information. In this section, there should be a description of the qualitative and/or quantitative methods the therapist employed in monitoring the therapy as it was taking place. These can include: (a) the therapist's analysis of previous sessions and self-reflection; (b) supervision; (c) patient-completed quantitative questionnaires; (d) peer feedback; and/or (e) feedback from other professionals who have worked with the client. If applicable, this section should also include a description of how the resulting monitoring feedback was used to revise earlier steps in the therapy.

8. Concluding Evaluation of the Therapy's Process and Outcome. This section should include the following:

A) The outcome of the therapy vis a vis alleviating the client's presenting problems and attaining the client's goals should be described at termination and, ideally if possible, at follow-up time(s).

B) A summary statement of the ways in which the Guiding Conception played out in the stages 4-7 above should be set forth, including a critical analysis of the strengths and weaknesses of the Guiding Conception in this case.

C) Where possible, comparisons to previously published cases should be made.

D) Managed care and other funding related issues associated with the case should be described.

E) Recommendations to clinicians and students should be explored.

F) Any other relevant comments not covered above should be laid out.

References

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Eells, T.D. (Ed.). (1997). *Handbook of psychotherapy case formulation.* NewYork: Guilford.
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Stricker, G., & Trierweiler, S.J. (1995). The local clinical scientist: A bridge between science and practice. *American Psychologist, 50*, 995-1002.